DERMATOLOGY OF NOBLESVILLE

116 Lakeview Drive
Noblesville, IN 46060
(317) 773-7400 FAX (317) 773-9029

Enclosed are your New Patient registration papers. The patient is responsible for contacting their insurance company to ensure that Dr. Karl Siebe (Dermatology of Noblesville) is in their network. We ask that you call the telephone numbers on the back of your insurance card(s) to verify that Dr. Karl Siebe is in your network. Please complete the enclosed papers or visit our website at DermatologyofNoblesville.com to print our New Patient registration forms. Please bring the following to your appointment: registration papers, actual insurance card(s) for scanning, list of your current medications with the dosage(s), and your co-pay (if applicable), which is due at the time of your appointment.

Thank You,
Dr. Karl W. Siebe/jm

Dermatology of Noblesville

REGISTRATION FORM

(Please Print)

Today's date: | Referred by:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

City:	State:	Zip Code:	Cell phone no.: ( )

Occupation:	Employer:	Employer phone no.: ( )

Referred to Doctor by (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Name of primary insurance company:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of Medicare secondary insurance:	Subscriber's name:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dermatology of Noblesville or insurance company to release any information required to process my claims. Any and all fees or expenses incurred in the collection of overdue accounts will be the responsibility of patient.

Patient/Guardian signature *Date*

EMAIL ______________________________