SOUTHERN DERMATOLOGY PATIENT INFORMATION
PLEASE FILL OUT ALL INFORMATION REQUESTED

TODAYS DATE: _____/_____/_____

Patient's Name: _____
Last First Middle
□ Mr. □ Mrs. □ Ms. □ Dr. □ Single □ Married □ Divorced □ Widow □ Legally Separated

Mailing Address: _____
City State Zip

Home Phone ( ) _____ Work Phone ( ) _____

Cell Phone ( ) _____ Alternate # ( ) _____

Email Address: _____

If patient is a minor, what is your relationship to patient: □ Mother □ Father □ Other: _____

Date of Birth: _____/_____/_____ Sex □ Male □ Female SSN: _____

For minor patients, please list parents name: _____

Mother's DOB: _____ Father's DOB: _____ Mother's Cell: _____ Father's Cell: _____

Primary Caregiver: _____ Referring Doctor: _____ Pharmacy: _____

INSURANCE INFORMATION- (PRIMARY)

Insurance Co. Name: _____SSN: _____

Name of Policy Holder (Insured): _____

Policy Holder's Date of Birth: _____/_____/_____ Name of Employer: _____

INSURANCE INFORMATION- (SECONDARY)

Insurance Co. Name: _____ SSN: _____

Name of Policy Holder (Insured): _____

Policy Holder's Date of Birth: _____/_____/_____ Name of Employer: _____

Do you give our office permission to discuss your medical information with family members? If yes, please provide their names and phone numbers: _____

May we leave personal medical information on your answering machine or cell phone? _____

May we e-mail personal medical information to you? Address: _____

I authorize any holder of medical or other information about me to release to the above insurance company(s) any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment. My Signature also indicates that I have received and or reviewed a copy of my physician's Notice of Used and Disclosures of Protected Medical Information. I have been given the option of signing a separate Patient Consent Form. I understand that I am responsible for paying my annual deductible, co-payment and charges for any non-covered or cosmetic services at the time of service. Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 50% of the total bill at the time of the service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Signature of Responsible Party Date

Please bring your insurance card (s) and photo I.D. to the receptionist so copies may be made.