

North Georgia Dermatology, P.C.

Patient Information

Patient's Last Name: _____	First Name: _____	MI: _____	Date: _____
Date of Birth: _____	Age: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security #: _____
Address: _____		Pharmacy #: _____	
City: _____	State: _____	Zip: _____	Home Phone: _____
Patient's Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed		Cell Phone: _____	
Employer: _____		Occupation: _____	
Work Phone: _____		How did you hear about this practice? <input type="checkbox"/> Physician <input type="checkbox"/> Yellow pages <input type="checkbox"/> Insurance <input type="checkbox"/> Hospital <input type="checkbox"/> Friend <input type="checkbox"/> Other _____	
Primary Care Physician: _____		Referring Physician: _____	
In case of emergency, contact: _____			
Home Phone: _____		Work Phone: _____	
Relationship: _____		Other family members seen by our physicians: _____	

Guardian Information (if Patient is a Minor)

Last Name of Guardian: _____	First Name: _____	MI: _____
Date of Birth: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security #: _____
Address: _____		
City: _____	State: _____	Zip: _____
Home Phone: _____		
Relationship to Patient: _____		
Guardian's Employer: _____		
Occupation: _____		
Work Phone: _____		

Insurance Information

Please Give Receptionist All Insurance Identification Cards to be Copied	Check One: <input type="checkbox"/> Group <input type="checkbox"/> Individual	
Owner of Policy Last Name: _____	First Name: _____	MI: _____
Date of Birth: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security #: _____
Address: _____		
City: _____	State: _____	Zip: _____
Home Phone: _____		
Relationship to Patient: _____		
Employer: _____		
Occupation: _____		
Work Phone: _____		

PLEASE READ CAREFULLY:

I understand I am responsible for payment of services, and that payment is due when services are rendered. I further understand that insurance may be filed by your office as a courtesy, and does not constitute a contract between the physician and insurance company for payment of your services.

If paying by check, you authorize us to use information from your check to process a one-time Electronic Funds Transfer (EFT) from your account and you will not receive your check from your financial institution. In the event of a returned check, a \$37.00 fee will be added to your balance. We do not accept third-party checks. We do not "hold" checks.

I also acknowledge that credit balances of \$10.00 or less will remain on my account, unless I request a refund amount over \$10.00 will be automatically refunded.

There is a \$30.00 charge for missed appointments or failure to give 24 hour notice.

Authorization to File Insurance:

I hereby authorize the release of any medical information to any company with whom I have medical or surgical benefits for the purpose of filing a medical or surgical claim. I also authorize my insurance carrier to pay charges to North Georgia Dermatology, P.C. if I have not paid the incurred charges.

Patient or Authorized Person's Signature