North Georgia Dermatology, P.C.

Patient Information

Patient's Last Name: _____ First Name: _____ MI: _____ Date: _____
Date of Birth: _____ Age: _____ ❑ Male ❑ Female Social Security #: _____
Address: _____ Pharmacy #: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Email: _____
Patient's Marital Status: ❑ Married ❑ Divorced ❑ Single ❑ Widowed
Primary Language: ❑ English ❑ Spanish ❑ Other: _____
Race: ❑ Caucasian ❑ Black/African American ❑ Hispanic ❑ Other: _____
Ethnicity: ❑ Non Hispanic/Latino ❑ Hispanic ❑ Latino ❑ Other: _____
Employer: _____ Occupation: _____ Work Phone: _____
How did you hear about this practice? ❑ Physician ❑ Insurance ❑ Family/Friend ❑ Internet ❑ Mailer ❑ Other: _____
Please list the names of people our staff can discuss your medical care with:

Name	Relationship	Phone #

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/or dependent Student)*

Name of Guardian: _____ First Name: _____ MI: _____
Date of Birth: _____ ❑ Male ❑ Female Social Security #: _____
Address: _____
City: _____ State: _____ Zip: _____ Home Phone: _____
Relationship to Patient: _____
Guardian's Employer: _____ Occupation: _____ Work Phone: _____

Insurance Information

Owner of Policy Last Name: _____ First Name: _____ MI: _____
Date of Birth: _____ ❑ Male ❑ 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.

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 $50.00 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