DERMATOLOGY CLINIC OF JACKSON

PATIENT INFORMATION

FIRST_____MIDDLE_____ LAST_____

BIRTHDATE_____ AGE_____ SS#_____MARITAL STATUS_____ SEX_____RACE_____
(SOCIAL SECURITY NUMBERS ARE USED FOR IDENTIFICATION AND INSURANCE VERIFICATION PURPOSES ONLY)

ADDRESS_____P.O. BOX_____

CITY_____STATE_____ZIP_____EMPLOYER_____

PHONE#_____ CELL PHONE# _____

EMERGENCY CONTACT & PHONE # _____

RESPONSIBLE PARTY INFORMATION

PRIMARY INSURANCE _____SECONDARY_____

NAME (IF OTHER THAN PATIENT)_____BIRTHDATE_____

SS #_____RELATIONSHIP TO PATIENT_____EMPLOYER_____

MEDICAL INFORMATION

REFERRING PHYSICIAN_____REASON FOR VISIT_____

PRESCRIPTION DRUG ALLERGIES_____

CURRENT PRESCRIPTION MEDICATIONS _____

_____

AUTHORIZED INDIVIDUALS TO DISCUSS RESULTS

NAME_____RELATION_____PHONE#_____

NAME_____RELATION_____PHONE#_____

Read the following release of information. Please sign and date.

I agree to and authorize medical treatment as deemed necessary by Dermatology Clinic of Jackson. I hereby authorize Dermatology Clinic of Jackson to furnish information concerning my treatment to insurance companies as deemed necessary, and I hereby irrevocably assign to Dermatology Clinic of Jackson all insurance benefits payable to me by my insurance company, not to exceed the charges shown. I understand I am financially responsible for any amounts that are not covered by my insurance and this authorization. Dermatology Clinic of Jackson cannot accept responsibility for collecting insurance claims or for negotiating a settlement on a disputed claim. I understand I am responsible for my account. The undersigned further agrees that in the event his/her account is turned over to an attorney, the undersigned shall be responsible for all costs of collection, including out of pocket expenses, court costs, and attorney fees. I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dermatology Clinic of Jackson for any services furnished me by that clinic. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

SIGNED:_____DATE_____

(PATIENT OR RESPONSIBLE PARTY)

REV 7/17