MT. PLEASANT DERMATOLOGY, LLC

PATIENT INFORMATION FORM (Please print)

This Form Must Be Filled Out Yearly

Full Legal Name _____
(Last) (First) (MI)

Nickname _____ **Social Security Number** _____

Date of Birth _____ **Male** _____ **Female** _____

Mailing Address _____

City _____ **State** _____ **Zip Code** _____

Alt Address *(if applicable)*

_____

Primary Phone _____ **Secondary Phone** _____

Email _____

Occupation _____ **Employer** _____

If Student Name of School _____

Preferred Language _____

Race □ White □ African American □ Alaska Native or American Indian □ Asian

□ Native Hawaiian or Pacific Islander □ Other _____ □ Decline to Specify

Ethnic Group □ Hispanic or Latino □ Not Hispanic or Latino □ Decline to Specify

Guarantor (Responsible Party)

Name _____

Date of Birth _____ **Relationship to Patient** _____

Address *(if different from above)* _____

Home Phone (____)_____ **Work Phone** (_____)_____ **Male** ____ **Female** _____

Employer _____ **Address** _____

Primary Care Physician _____

Address _____ Phone (____)_____

Referring Physician _____

Address _____ Phone (____)_____

Preferred Pharmacy _____ Phone (____)_____

Emergency Contact Name _____

Relationship _____ **Phone** _____

PLEASE PRESENT INSURANCE CARDS TO RECEPTIONIST SO COPIES CAN BE MADE

Insurance Information

Medical Insurance: If your insurance policy requires a copayment, percentage, or deductible, this amount is payable at the time services are rendered. If our office is not a participating provider for your insurance or if a required referral has not been obtained, then payment is expected in full at the time of service.

This information below is in regards to the person whose name appears on the insurance card.

PRIMARY Insurance _____

ID # _____ **Group #** _____

Insurance Address _____

Name of Insured _____

Insured's SSN _____ **Insured's Date of Birth** _____

Employer Name _____

SECONDARY Insurance _____

ID # _____ **Group #** _____

Insurance Address _____

Name of Insured _____

Insured's SSN _____ **Insured's Date of Birth** _____

Employer Name _____

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Authorization, Assignment of Benefits, and Referral Medical Releases

I consent and authorize a Mt. Pleasant Dermatology physician and whomever they may designate as their assistant to provide me medical treatment and to use and disclose my protected health information for treatment, payment and healthcare operations as allowed by HIPAA and as described in the Mt. Pleasant Dermatology Notice of Information Practices.

I authorize the release of medical information, including complete medical records, test results, and billing information to my insurance company, to the other medical professionals, and/or medical care institutions that I may be referred to for treatment and for payment purposes.

I authorize payment directly to Mt. Pleasant Dermatology for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurances, deductibles, and non-covered services.

A photocopy of this form shall be considered as effective and as valid as the original.

To the best of my knowledge the information I have provided on this form is accurate and true. I recognize it is my or my legal guardian's responsibility to keep this practice and my physician informed of changes to

any of my contact information. A failure to do so may impact my ability to receive proper care for a medical condition.

Patient Legal Signature _____ Date_____

Legal Guardian Name (Print) _____ Relationship _____

Guardian Signature _____ Date _____