

**GWINNETT DERMATOLOGY, PC  
PATIENT INFORMATION**

PATIENT INFORMATION (PLEASE PRINT)				ACCOUNT#		
LAST NAME	FIRST NAME & M.I.	NAME CALLED BY	MARITAL STATUS M S W D SEP	DATE OF BIRTH	AGE	SEX M F
STREET ADDRESS		CITY AND STATE	ZIP CODE	PATIENT HOME#		
PATIENT'S EMPLOYER		OCCUPATION	<input type="checkbox"/> RETIRED <input type="checkbox"/> STUDENT	PATIENT CELL#		
EMPLOYER'S STREET ADDRESS		CITY AND STATE	ZIP CODE	PATIENT WORK#		
IN CASE OF EMERGENCY		EMERGENCY CONTACT #	PATIENT EMAIL			
REFERRED BY	PRIMARY CARE PHYSICIAN	OTHER FAMILY MEMBERS SEEN IN OFFICE				
PERSON RESPONSIBLE FOR PAYMENT (IF DIFFERENT FROM ABOVE)						
LAST NAME	FIRST NAME & MIDDLE INITIAL	RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> FATHER <input type="checkbox"/> MOTHER <input type="checkbox"/> OTHER				
STREET ADDRESS		CITY AND STATE	ZIP CODE	HOME #		
EMPLOYER						CELL #
EMPLOYER'S STREET ADDRESS		CITY AND STATE	ZIP CODE	WORK#		
COMPLETE IF PATIENT IS A MINOR OR DEPENDENT STUDENT						
CONTACT NAME	RELATIONSHIP TO PATIENT <input type="checkbox"/> FATHER/STEP FATHER <input type="checkbox"/> MOTHER/STEP MOTHER <input type="checkbox"/> GUARDIAN			HOME #		
STREET ADDRESS		CITY AND STATE	ZIP CODE	CELL #		

PATIENT PRIVACY INFORMATION			
I hereby authorize Gwinnett Dermatology, P.C., and staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.			
HOME #	CELL #	WORK #	EMAIL
Gwinnett Dermatology will only leave a message on your answering machine with your permission. May we leave a message on your answer machine: Yes _____ No _____			
I hereby authorize Gwinnett Dermatology, P.C., and staff to fax or mail medical information pertaining to my care to a referred or referring healthcare provider and will assume responsibility to notify them whenever this information changes.			
PLEASE LIST THE NAMES OF PEOPLE OUR STAFF CAN DISCUSS YOUR MEDICAL CARE WITH			
SPOUSE NAME	PARENT NAME	OTHER	
CONTACT PHONE#	CONTACT PHONE#	CONTACT PHONE#	

I understand that I am financially responsible for all services rendered. If I am covered by an insurance company that requires a referral from my primary care physician, it is my responsibility to obtain that referral authorization prior to my visit. I will pay the charges I am responsible for today, whether it is a copayment, deductible, coinsurance or payment in full by the following method  Cash  Check  Visa/MC  Discover

\_\_\_\_\_ Patient Initials

PAYMENT AUTHORIZATION I authorize insurance payment, if any, directly to Gwinnett Dermatology, PC. I realize I am responsible for non-covered services.

\_\_\_\_\_ Patient Initials

INFORMATION RELEASE I authorize Gwinnett Dermatology, PC to release to my insurance carriers or to the Social Security Administration and Health Care Financing Administration any information needed to determine benefits payable to related services. 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 to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

\_\_\_\_\_ Patient Initials

ACKNOWLEDGEMENT I acknowledge all information above is accurate.	
Signature of Patient or Legal Guardian, if a minor	Date





