JACKSONVILLE DERMATOLOGY ASSOCIATES, PL

PATIENT INFORMATION

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS:

Name _____
Last *First* *M.I.*

Date of Birth: ____/____/____ Age: _____ Gender: □ Male □ Female SSN: xxx-xx-_ _ _ _

Race:_____ Ethnicity:_____ Preferred Language:_____

Mailing Address_____

City_____State_____ZipCode_____

Home Phone:( )_____Cell Ph: ( )_____Work Ph: ( )_____

Email Address: _____

Referred by: _____

Primary Care Physician _____ Phone ( )_____

RESPONSIBLE PARTY, PARENT, OR SPOUSE *(if different from patient)*

Name: _____Date of Birth: ____/____/____
Last *First* *M.I.*

Address:_____
City *State* *Zip*

Primary Phone: ( )_____ Secondary Phone: ( )_____

INSURANCE CARRIER INFORMATION:

Primary Insurance Carrier: _____Insured's Name_____Ins DOB_____

Secondary Insurance Carrier: _____Insured's Name_____Ins DOB_____

I authorize any holder of medical or other information about me to release to the above insurance company(s) any information needed for this or a related insurance claim. 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 the party who accepts assignment.

Date: ____/____/____ Signature: _____

Please provide your insurance card(s) and driver's license to the receptionist along with this form.

Patient Name:_____ Today's Date ____/____/____

Other family members that are patients _____

Employer:_____ Occupation:_____

EMERGENCY CONTACT INFORMATION:

In case of Emergency, who should be notified?_____ Phone ( )_____

Relationship to patient: _____

Do you give our office permission to discuss your medical information with family members?

❑ YES ❑ NO If yes, please provide their names and phone numbers below.

Name: _____ Relationship: _____

Phone # (day): (_____)_____ Phone # (evening): (_____)_____

Name: _____ Relationship: _____

Phone # (day): (_____)_____ Phone # (evening): (_____)_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form. I also indicate by my signature below that I have no unanswered questions about HIPPA policies of this office.

Patient or Responsible Party Signature _____ Date ____/____/____

PAYMENT POLICY: ***No show fee:*** You will be responsible for paying a $25 no show fee for an appointment missed or not cancelled 24 hours in advance. For a surgical appointment, the no show fee is $75.

HMO, PPO or other managed care patients: You will be responsible for paying your annual deductible, copayment and charges for any non-covered, cosmetic services at the time of service.

Other Patients: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 50% of the total bill at the time of the service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier and any payment or reimbursement to you.

Patient or Responsible Party Signature _____ Date ____/____/____