

# North Georgia Dermatology, P.C.

Steven A. Freedman, M.D.

Cynthia A. Dolan, M.D.

Joy M. Stevens, NP-C

## Patient Information

Patient's Last Name: _____	First Name: _____	MI: _____	Date: _____
Date of Birth: _____	Age: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security #: _____
Address: _____			
City: _____	State: _____	Zip: _____	Home Phone: _____
Patient's Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed			
Employer: _____		Occupation: _____	Work Phone: _____
How did you hear about this practice? <input type="checkbox"/> Physician <input type="checkbox"/> Yellow pages <input type="checkbox"/> Insurance <input type="checkbox"/> Hospital <input type="checkbox"/> Friend <input type="checkbox"/> Other _____			
Primary Care Physician: _____		Referring Physician: _____	
In case of emergency, contact: _____			
Home Phone: _____		Work Phone: _____	Relationship: _____
Other family members seen by our physicians: _____			

## Guarantor Information (if Different from Patient)

Last Name of Guarantor: _____	First Name: _____	MI: _____
Date of Birth: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security #: _____
Address: _____		
City: _____	State: _____	Zip: _____
Home Phone: _____		
Relationship to Patient: _____		
Guarantor's Employer: _____		Occupation: _____
Work Phone: _____		

## Insurance Information

<b>Please Give Receptionist All Insurance Identification Cards to be Copied</b>	Check One: <input type="checkbox"/> Group <input type="checkbox"/> Individual	
Owner of Policy Last Name: _____	First Name: _____	MI: _____
Date of Birth: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security #: _____
Address: _____		
City: _____	State: _____	Zip: _____
Home Phone: _____		
Relationship to Patient: _____		
Employer: _____		Occupation: _____
Work Phone: _____		

I will be paying for visits by:  Cash  Check  VISA  MasterCard  Discover

### 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

Return checks are handled by an outside company, Check Care. I also acknowledge that credit balances of \$10.00 or less will remain on my account, unless I request a refund. Amounts over \$10.00 will be automatically refunded. There is a \$20.00 charge for missed appointments or failure to give 24 hour notice.

\_\_\_\_\_  
Patient or Authorized Person's Signature

### Authorization to File Insurance:

I hereby authorize the release of any medical information to any insurance 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