DERMATOLOGY CLINIC OF JACKSON

Patient's Name: _____ Age: _____ Sex: _____ Race: _____

SS #: _____ Birthdate: _____ Marital Status: _____

Address: Street: _____ P.O. Box: _____

City: _____ State: _____ Zip Code: _____

Telephone: Home #: _____ Work #: _____ Cell #: _____

Employer Name / Address / Phone: _____

_____

Allergies to drugs: _____

Reason for Visit: _____

Current Medications: _____

Referring Physician Name / Address: _____

Friend / Relative
not living with you: _____ Phone #: _____

Authorized Individuals to discuss results:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

PRIMARY INSURANCE INFORMATION

Insurance Name: _____

Insured Name: _____ Birthdate: _____

ID#: _____ Group / Policy #: _____

SS# of Insured: _____

_____

_____

SECONDARY INSURANCE INFORMATION

Insurance Name: _____

Insured Name: _____ Birthdate: _____

ID#: _____ Group / Policy #: _____

Employer Name / Address / Phone: _____
(If different from above)

_____

RESPONSIBLE PARTY INFORMATION
(if different from Patient)

Name: _____ _____ _____
FIRST MI LAST

SS #: _____

Home Address: _____

City: _____ St.: _____ Zip: _____

Mailing Address (if different): _____

City: _____ St.: _____ Zip: _____

Sex: _____ Date of Birth: _____ Marital Status: _____

Telephone: Home: #: _____ Work #: _____

Employer Name/Address/Phone: _____

_____

_____

SPOUSE INFORMATION

Spouse Name: _____

Birthdate: _____

Employer Name/Address/Phone: _____

_____

DO YOU HAVE A LIVING WILL OR DURABLE POWER OF ATTORNEY? YES NO

WOULD YOU LIKE INFORMATION ON A LIVING WILL OR DURABLE POWER OF ATTORNEY? YES NO

INFORMATION PACKET GIVEN TO PATIENT: DATE : _____ INITIALS: _____

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 its agents any information needed to determine these benefits or the benefits payable for related services.

SIGNED: _____ **SIGNED:** _____
(Patient or Responsible Party) **(Patient or Responsible Party)**

DATE: _____ **DATE:** _____