



PATIENT REGISTRATION

Name _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____ Language _____

Primary Phone (____)____-____-____ Secondary Phone (____)____-____-____

Primary Phone will be used for Appointment Reminder Calls

SS# ____ - ____ - ____ Birthplace _____ Race _____ Ethnicity _____

Date of Birth ____/____/____ Age ____ Male ____ Female ____ Marital Status _____
MM DD YYYY

E-Mail _____ Referring Doctor _____

Pharmacy Phone Number(____)____-____-____ How did you hear about our practice? _____

Emergency Contact _____ Relationship _____ Phone#(____)-____-____-____

PRIMARY INSURANCE INFORMATION

Insurance _____

Policy Holder Name _____ SS# ____ - ____ - ____ Relationship _____

Policy Holder Date of Birth ____ - ____ - ____ Work# (____)____-____-____
MM DD YYYY

SECONDARY INSURANCE INFORMATION

Insurance _____

Policy Holder's Name _____ SS# ____ - ____ - ____ Relationship _____

Do you have a 3rd insurance? ____ Yes ____ No If yes, Insurance _____

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Georgia Dermatology or my insurance company to release any information required to process my claims.

Signature _____ Date _____