Stones River Dermatology, PLC
Patient Information and Insurance Authorization

PATIENT INFORMATION

Name _____

Mailing Address _____

City/State/Zip _____

Primary Phone _____ Additional Phone _____

Employer _____

Work Phone _____ Extension _____

Date of Birth _____ Age _____

Please circle: Single Married Divorced Sex (please circle) M F

Social Security Number_____

PARENT, SPOUSE, OR RESPONSIBLE PARTY (if other than patient)

Name _____

Mailing Address _____

City/State/Zip _____

Home Phone _____ Cell Phone _____

Employer _____

Work Phone _____ Extension _____

Relationship to Patient _____

INSURANCE CARRIER INFORMATION

Primary Insurance Carrier _____

Policy Holder Name _____ Policy Holder Date of Birth & Relation_____

Identification Number _____ Group Number _____

Secondary Insurance Carrier _____

Policy Holder Name _____ Policy Holder Date of Birth & Relation_____

Identification Number _____ Group Number _____

I authorize Stones River Dermatology, PLC, to bill my insurance company for medical services rendered and receive payment directly from my insurance company. I permit a copy of this authorization to be used in place of the original and consent to the release of medical information necessary to process any insurance claims. I also consent to the release of medical information to other physicians who may participate in my treatment. The information provided above is accurate to the best of my knowledge. I have read and received the Stones River Dermatology Insurance and Billing Practices information sheet.

Signature _____ **Date** _____

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ADDITIONAL QUESTIONS

Do we have your permission to:

Call you at work with medical information?	YES	NO
Leave a voice mail or answering machine message at home?	YES	NO
Leave a voice mail or answering machine message at work?	YES	NO
Leave a message with your spouse or someone who lives with you?	YES	NO
Use e-mail to communicate with you?	YES	NO

E-mail address:_____

WARNING: E-mail may not protect your confidential medical information. I recognize any confidential medical information transmitted by e-mail is not secure and sent at my own risk. I will not hold Dr. Nelson or Stones River Dermatology responsible for the loss of any confidential medical information transmitted by e-mail. Dr. Nelson and Stones River Dermatology will limit our use of unencrypted e-mail to prevent disclosure of protected health information.

Do you have an Advance Directive (Living Will)?	YES	NO
Do you want a copy of the Notice of Privacy Practices?	YES	NO
May we discuss your medical information with anyone other than you?	YES	NO

Name _____

Relationship _____

Phone _____

Please list an emergency contact person (relative or friend not living with you):

Name _____

Relationship _____

Phone _____

PLEASE PRESENT YOUR INSURANCE CARDS AND DRIVER'S LICENSE OR OTHER PHOTO IDENTIFICATION TO THE RECEPTIONIST. THE RECEPTIONIST WILL MAKE COPIES AND RETURN THEM TO YOU PROMPTLY.

Dr. Nelson and Stones River Dermatology appreciate your patronage!

I acknowledge all of the above information is correct. I authorize Dr. Nelson and the staff of Stones River Dermatology to use the contact information above in treatment of my medical conditions.

Signature _____ **Date** _____