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 Other

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 Stones River Dermatology responsible for the loss of any confidential medical information transmitted by e-mail. 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.

Stones River Dermatology appreciates your patronage!

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

Signature ____ **Date** ______________________