

Patient's Name: _____ Date of Birth: _____ Today's Date: _____

Address: _____ Apt#: _____ City/State: _____ Zip: _____

Phone#: _____ [] cell [] home [] work Add'l Phone#: _____ [] cell [] home [] work

Email: _____ Do we have permission to leave a message: [] Cell [] Home [] Work [] Email

Discuss your medical condition with someone? [] NO [] YES If YES, whom: _____

Insurance: _____ 2nd Insurance: _____ *If any changes please give Insurance cards to Front Desk

Medical Information: Reason for today's visit: _____

Please list all medications (including over-the-counter & herbals): _____

Are you allergic to any medications? [] NO [] YES, please list: _____

List any diseases or conditions: _____

List any surgical procedures you have had in the last year: _____

Primary Care Physician: _____ Phone #: (____) _____ - _____

Use tobacco products: [] NO [] YES, amount: _____ Drink alcohol: [] NO [] YES, amount: _____ [] day [] week

Flu Vaccine received: [] NO [] YES, date: _____ Pneumococcal Vaccine received: [] NO [] YES, date: _____

Woman: Are you pregnant? [] NO [] YES Breastfeeding: [] NO [] YES

Guarantor Agreement / Acknowledgment of Notice of Privacy Practices / Laboratory Authorization

I authorize Memorial Dermatology / Greg William Pearson, M.D. to release any information necessary to process my claims for health benefits. I agree to assign the benefits of my insurance carrier to Memorial Dermatology / Greg William Pearson, M.D. I understand that Memorial Dermatology / Greg William Pearson, M.D. will file my insurance claim as a courtesy to me, and as such, is not required to wait extended delays in payment. I understand that I am fully responsible for any non-covered services, denied services, health insurance deductible/copay/coinsurance, or unassigned portions of charges at this office.

I have received (upon request) a copy of the Notice of Privacy Practices for Memorial Dermatology / Greg William Pearson, M.D. I consent to the use and sharing of my health records for treatment. Payment and operation purposes as described in the notice. I know if I do not consent, services cannot be provided to me.

By providing your email you agree to receive promotional and informative emails from our office. You have to the option unsubscribe at any time.

Laboratory Authorization: Skin, nail and hair samples are routinely sent to a laboratory for microscopic evaluation to determine or confirm proper diagnosis. I authorize and understand that I am responsible for the cost of any testing or lab services performed for me and that billing of such services may be billed independently by another physician or laboratory. I further understand that any balance not paid after 90 days, regardless of insurance coverage, may be referred to a collection agency.

Cosmetic Services: A cosmetic consult is not covered by your insurance, therefore it is the responsibility of the patient, and the consult fee is not applied to services rendered. All cosmetic packages expire 1 year from the purchase date. A deposit is required for all cosmetic appointments. The deposit will go towards the cost of the services rendered. You will forfeit your deposit if the appointment is not cancelled at least 24 hours prior.

Surgery/Procedures: Most insurance companies consider all dermatology procedures (such as skin biopsies or freezings) to be surgical in nature. They will often apply these costs to your deductible/coinsurance. The patient responsibility is due at the time services are rendered. Please ask the staff for a cost estimate if you would like to know beforehand. A deposit may be required for surgery appointments. The deposit will go towards the cost of the services rendered. You will forfeit your deposit if the appointment is not cancelled at least 24 hours prior.

My signature below signifies my understanding and willingness to comply with this policy.

Consenting Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____