Memorial Dermatology

Patient's Name: ____ **Date of Birth**: __________________ **Today's Date**: _______________

Address: ____ **Apt#**:_______**City/State**: _____________________ **Zip**: ___________

1st Phone#:___________________________ [ ] cell [ ] home [ ] work **2nd Phone#**:_____________________________ [ ] cell [ ] home [ ] work

Email: ____ *Do we have permission to: Leave a message?* [ ] Cell [ ] Home [ ] Work [ ] Email

Discuss your medical condition with someone? __________ *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: ____

PCP:____

Use tobacco products: [ ] NO [ ] YES

Drink alcohol: [ ] NO [ ] YES, amount: _____ [ ] day [ ] week [ ] month

Flu Vaccine received: [ ] NO [ ] YES, date: ________

Pneumococcal Vaccine received: [ ] NO [ ] YES

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.

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.

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

Consenting Name: ____ Relationship to Patient: ______________________

Signature: ____ Date: ____________________________