

(PLEASE PRINT AND COMPLETE ENTIRE FORM)

SOCIAL SECURITY NUMBER \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE \_\_\_\_\_

NAME OF PATIENT  
FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_ LAST \_\_\_\_\_

MAILING ADDRESS  
STREET \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PH \_\_\_\_\_ WORK PH \_\_\_\_\_ CELL PH \_\_\_\_\_ E-MAIL \_\_\_\_\_

DOB \_\_\_\_\_ AGE \_\_\_\_\_ SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_ WIDOWED \_\_\_\_\_ DIVORCED \_\_\_\_\_

OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_ PH \_\_\_\_\_

REFERRED BY \_\_\_\_\_ FAMILY PHYSICIAN \_\_\_\_\_

REASON FOR APPOINTMENT: \_\_\_\_\_

PREFERRED PHARMACY \_\_\_\_\_ PHONE \_\_\_\_\_

COMPLETE ONLY IF MINOR OR STUDENT:

FATHER'S NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_

SS# \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

MOTHER'S NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_

SS# \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

PERSON RESPONSIBLE FOR MEDICAL BILLS:

NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_

PRIMARY INS \_\_\_\_\_ POLICY# \_\_\_\_\_ GROUP \_\_\_\_\_

SECONDARY INS \_\_\_\_\_ POLICY# \_\_\_\_\_ GROUP \_\_\_\_\_

**FEE POLICY**

I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT OF ALL FEES FOR PROFESSIONAL SERVICES RENDERED BY THIS OFFICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. I ALSO AUTHORIZE GREENVILLE DERMATOLOGY LLC TO RELEASE TO MY INSURANCE COMPANY ANY INFORMATION CONCERNING MY HEALTHCARE, FOR THE PURPOSE OF PROCESSING INSURANCE CLAIMS.

I HAVE RECEIVED A COPY OF THE PRIVACY NOTICE FOR GREENVILLE DERMATOLOGY LLC.

PATIENT SIGNIATURE / LEGAL GAURDIAN: \_\_\_\_\_ DATE \_\_\_\_\_