PATIENT INFORMATION *Georgia Skin Specialists, P.C.*

PATIENT NAME: _____ PREFERRED NAME: _____

DATE OF BIRTH: _____ /_____ / _____ SEX: ☐ MALE ☐ FEMALE ☐ OTHER

SSN: _____ MARITAL STATUS: _____ PREFERRED PRONOUNS: _____

PATIENT ADDRESS: _____ UNIT NUMBER:_____

CITY/STATE/ZIP: _____

Please check the box to indicate your **primary** phone number:

☐ HOME PHONE: _____ ☐ WORK PHONE: _____

☐ CELL PHONE: _____

EMAIL ADDRESS: _____@_____._____

RACE: ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN
☐ HAWAIIAN/PACIFIC ISLANDER ☐ WHITE/CAUCASIAN ☐ OTHER
☐ UNKNOWN ☐ DECLINED

ETHNICITY: ☐ NOT HISPANIC OR LATINO ☐ HISPANIC OR LATINO ☐ DECLINED ☐ UNKNOWN

LANGUAGE: _____

EMERGENCY CONTACT NAME: _____ RELATIONSHIP TO PATIENT: _____

EMERGENCY CONTACT HOME PHONE: _____ CELL PHONE: _____

PRIMARY CARE PHYSICIAN: _____ REFERRING PHYSICIAN: _____

PRIMARY PHARMACY: _____ PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE PLAN NAME: _____ EFFECTIVE DATE: _____

POLICY HOLDER: _____ **POLICY HOLDER** DATE OF BIRTH: _____

INSURANCE ID#: _____ GROUP #:_____

SECONDARY INSURANCE PLAN NAME: : _____ EFFECTIVE DATE: _____

POLICY HOLDER: _____ **POLICY HOLDER** DATE OF BIRTH: _____

INSURANCE ID#: _____ GROUP #:_____

ASSIGNMENT AND RELEASE OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include Major Medical Benefits to which I am entitled, including Medicare, private insurance, and any other health plan to: **Georgia Skin Specialists, P.C.**

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. **I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release medical information to secure payment.**

SIGNED: _____ DATE: _____