Patients under the age of 18 require a guarantor on file. Please complete the following for our records.

Patient Name (as it appears on patient insurance card): _____

Patient Date of Birth: _____

Guarantor Information (Financially Responsible for Patient Balances for above Patient):

Parent/Guardian's Name: _____ Date of Birth: _____

Parent/Guardian's Street Address: _____ Unit/Apt No.: _____

City/State: _____ Zip: _____

Parent/Guardian's Telephone:

Home: _____ Work: _____ Cell: _____

Parent/Guardian's Email Address: _____

Note: The above information will be used for patient billing. This is the address where patient statements will be sent, and the number our office or representatives will use for billing concerns.

I understand that I may remove these privilege or change the information on this form by notifying Georgia Skin Specialists in writing.

Printed Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ Date: _____