DERMATOLOGY OF ATHENS

Main Address
2000 Prince Avenue
Athens, GA 30606

1220 Langford Drive
Bldg 100, Suite 103
Watkinsville, GA 30677

Primary Care Doctor _____ Referring Doctor _____

Patient Name _____
First Middle Last

SS#_____ Birthdate _____ Age _____ Sex (M/F)_____ Marital Status _____

Address_____ City _____State _____ Zip _____

Home Phone_____ Cell Phone_____ Work Phone_____Ext _____

Email:_____

Appointment Reminder (choose one): Call Home _____ Call Cell _____ Text _____

Employed By_____

Occupation: _____ Industry: _____

Business Address _____

Spouse or parent/guardian's name_____

Pharmacy Name _____

Pharmacy Address _____

RESPONSIBLE PARTY

Name of person responsible for this account _____

Relationship to patient_____ SS# _____ Birthdate _____

Address_____

Home Phone_____ Cell Phone _____ Work Phone _____ Ext _____

Employer / Address _____

INSURANCE INFORMATION

Primary Insurance Name_____ Secondary Insurance Name _____

Name of Insured _____ Name of Insured _____

Birthdate _____ SS# _____ Birthdate _____ SS# _____

Employer Name_____ Employer Name_____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature_____ Date _____