Allen Dermatology and Skin Cancer Center

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(478) 477-6700

NAME: _____ **DATE OF BIRTH:** _____ **AGE:** _____

IF YOU ARE UNDER THE AGE OF 18, PLEASE COMPLETE THE FOLLOWING:

FATHER'S NAME: _____

MOTHER'S NAME: _____

OR

GUARDIAN'S NAME: _____

HOME ADDRESS:

_____

_____

_____

HOME PHONE NO.: _____

CELL PHONE NO.: _____

SOCIAL SECURITY NO.: _____

YOUR JOB:

_____

MARITAL STATUS: □ **SING** □ **MAR** □ **DIV** □ **WID** □ **SEP**

SPOUSE'S NAME: _____

WORK ADDRESS:

_____

_____

_____

E-MAIL ADDRESS:

_____

WORK PHONE NO.: _____

PHARMACY:

_____

_____

YOUR INSURANCE COMPANY: _____ **SECONDARY INSURANCE:** _____

ADDRESS: _____

POLICY/CONTACT #: _____

GROUP: _____

POLICY HOLDER'S NAME: _____

POLICY HOLDER'S DATE OF BIRTH: _____

MEDICARE #: _____ **HOSPITAL (A):** _____ **MEDICAL (B):** _____

EFFECTIVE DATE: _____ **(YOU MUST INFORM THE STAFF IF YOU ARE COVERED UNDER THE MEDICARE PROGRAM)**

ARE YOU ALLERGIC TO ANY MEDICINES? _____ **IF SO, WHAT** _____

LIST ALL OTHER ALLERGIES: _____

IF FEMALE, ARE YOU PREGNANT? _____ **IF SO, HOW FAR ALONG ARE YOU?** _____

IN CASE OF EMERGENCY, WHOM SHOULD WE CONTACT? _____

RELATION TO YOU: _____ **PHONE NO.:** _____

ADDRESS: _____

_____

_____

WHO REFERRED YOU TO OUR OFFICE: _____

PLEASE COMPLETE THE BACK OF THIS PAGE 

PERMIT TO BE TREATED

I, _____HEREBY
(PATIENT'S NAME OR IF PATIENT LESS THAN 18 YEARS OLD, PARENT/LEGAL GUARDIAN)
PERMIT _____TO BE SEEN AND TREATED BY DR. JENNIFER ALLEN OR
(SELF OR CHILD'S NAME)
DR. VIRGINIA HALL, THEIR MEDICAL ASSISTANTS, ASSOCIATES AND/OR OTHER APPROPRIATELY DESIGNATED PERSONNEL.

I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR MY MEDICAL BILL, THE BILL OF ANY MINOR OR CHARGE NAMED ABOVE AND I FURTHER AGREE TO PAY THE ENTIRE BILL AT THE TIME THE SERVICE IS RENDERED, UNLESS OTHER ARRANGEMENTS HAVE BEEN AGREED TO IN ADVANCE BY DR. ALLEN OR DR. HALL. I ALSO REALIZE AND AGREE THAT I AM FULLY RESPONSIBLE FOR ALL CHARGES AND BILLS INCURRED EVEN IF THE CHARGES ARE NOT COVERED BY OR ARE DENIED BY MY INSURANCE COMPANY, MEDICARE, SPONSORING AGENCY, ETC.

I AGREE THAT DR. ALLEN, DR. HALL AND/OR THIS OFFICE MAY RELEASE FOR THE PURPOSE OF VERIFYING DIAGNOSES, TREATMENTS, CHARGES AND/OR OTHER DATA ANY AND ALL INFORMATION IN MY RECORDS TO MY INSURANCE COMPANIES AND/OR SPONSORING AGENCIES.

I HAVE BEEN GIVEN INFORMATION DESCRIBING THE PRACTICE POLICIES OF THIS OFFICE AND OF DR. ALLEN/DR. HALL AND I REALIZE THAT IT IS MY RESPONSIBILITY TO READ IT OR HAVE IT READ TO ME AND I AGREE TO ABIDE BY SAME.

DATE:_____

SIGNED:_____
(PATIENT, PARENT OR LEGAL GUARDIAN)

WITNESS: _____

IF YOU WOULD LIKE US TO RELEASE INFORMATION TO ANYONE OTHER THAN AS NOTED ABOVE, PLEASE COMPLETE THE FOLLOWING:

I,_____, GIVE MY PERMISSION TO DR. ALLEN/DR. HALL AND THIS OFFICE TO RELEASE ANY INFORMATION CONCERNING MY MEDICAL CARE TO:

_____

_____

_____

SIGNED:_____DATE:_____