1924 Pinnacle Pointe Way, Suite 300
Knoxville, TN 37922
865.474.8800 phone
865.474.8806 fax


## PATIENT INFORMATION

| NAME (Last, First, Middle) | | SSN# | BIRTHDATE |
|---|---|---|---|
| MAILING ADDRESS | | CITY, STATE, ZIP | FAX (If Private) |
| HOME PHONE | | CELL PHONE | EMAIL ADDRESS (If Private) |
| MARITAL STATUS: M ☐ D ☐ W ☐ S ☐ | REFERRED BY: | | FORMER NAME (MAIDEN) |
| SPOUSE'S NAME | | WORK PHONE | CELL PHONE |

| EMPLOYER | CLOSEST RELATIVE'S NAME: | |
|---|---|---|
| ADDRESS | ADDRESS | |
| CITY, STATE, ZIP | CITY, STATE, ZIP | |
| WORK PHONE | PHONE | RELATIONSHIP |

## INSURANCE COMPANY INFORMATION

SOCIAL SECURITY #: ___________-_______-___________ DATE OF BIRTH: ______/______/______

PATIENT'S RELATIONSHIP TO INSURED PARTY: ☐ SELF ☐ SPOUSE ☐ DOMESTIC PARTNER ☐ PARENT ☐ OTHER________________________________________

*IF NOT SELF, PLEASE LIST INFORMATION FOR THE RESPONSIBLE PARTY
NAME:

| MAILING ADDRESS: | CITY, STATE, ZIP |
|---|---|
| HOME PHONE: | CELL PHONE: |
| PLACE OF WORK: | WORK PHONE: |

## PRIMARY INSURANCE

| NAME OF INSURANCE COMPANY | | POLICY# |
|---|---|---|
| NAME OF INSURED | | GROUP# |
| ADDRESS OF INSURANCE COMPANY | | COPAY AMT |
| CITY, STATE, ZIP | PHONE | EFFECTIVE DATE |

## SECONDARY INSURANCE (If Applicable)

| NAME OF INSURANCE COMPANY | | POLICY# |
|---|---|---|
| NAME OF INSURED | | GROUP# |
| ADDRESS OF INSURANCE COMPANY | | COPAY AMT |
| CITY, STATE, ZIP | PHONE | EFFECTIVE DATE |

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 whether by mail or by fax. I hereby release and discharge Southeastern Dermatology Consultants, PC from all liability in connection with such release of information. I also authorize payment of medical benefits to the physician**.** I also understand that regardless of any insurance coverage I may have, I am responsible for any bills incurred and will be responsible for any charges associated with collecting this debt. **While we will assist with billing your insurance company, you are primarily responsible for determining what your insurance will cover, whether you require a referral, and/or the payment of your bill**.

_____________________________________________ ____/____/______

Patient or Responsible Party Date

Updated: 2-Sep-09