

**ATHENS-OCONEE SKIN CANCER & DERMATOLOGY, LLC**  
**PATIENT INFORMATION SHEET**

DATE: \_\_\_\_\_ SOCIAL SECURITY# \_\_\_\_\_

PATIENT LAST NAME: \_\_\_\_\_ PATIENT FIRST NAME: \_\_\_\_\_ M.I.: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_ P.O. BOX/APT#: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_ SEX: \_\_\_M\_\_\_F AGE: \_\_\_ MARITAL STATUS: \_\_\_\_\_

F/T STUDENT \_\_\_Y\_\_\_N HOME PHONE: (\_\_\_\_) \_\_\_\_\_ CELL: (\_\_\_\_) \_\_\_\_\_

WORK: (\_\_\_\_) \_\_\_\_\_ EXT: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

SPOUSE/PARENT/GUARDIAN NAME: \_\_\_\_\_ SOC. SECURITY#: \_\_\_\_\_

SPOUSE/PARENT/GUARDIAN EMPLOYER: \_\_\_\_\_

WORK PHONE: (\_\_\_\_) \_\_\_\_\_ SPOUSE/PARENT/GUARDIAN CELL: (\_\_\_\_) \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_

DID THEY REFER YOU TO OUR OFFICE? YES/ NO (PLEASE CIRCLE)  
HOW DID YOU HEAR ABOUT OUR OFFICE? \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

(NOT LIVING WITH YOU)

STREET ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_

ZIP CODE: \_\_\_\_\_ EMERGENCY CONTACT PHONE: \_\_\_\_\_

(NOT LIVING WITH YOU)

**INSURANCE INFORMATION-PRIMARY POLICY**

INSURANCE COMPANY: \_\_\_\_\_ POLICY HOLDER DOB: \_\_\_/\_\_\_/\_\_\_

POLICY HOLDER'S LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ M.I. \_\_\_\_\_

POLICY HOLDER'S SS#: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

INSURED SEX \_\_\_M\_\_\_F EMPLOYER INSURANCE PLAN? \_\_\_Y\_\_\_N  
EMPLOYER \_\_\_\_\_

**INSURANCE INFORMATION-SECONDARY**

INSURANCE COMPANY: \_\_\_\_\_ POLICY HOLDER'S DOB: \_\_\_/\_\_\_/\_\_\_

POLICY HOLDER'S LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ M.I. \_\_\_\_\_

POLICY HOLDER'S SS#: \_\_\_\_\_ INSURED SEX: \_\_\_M\_\_\_F BIRTH DATE: \_\_\_/\_\_\_/\_\_\_

EMPLOYER'S INSURANCE PLAN? \_\_\_Y\_\_\_N EMPLOYER: \_\_\_\_\_



**ATHENS-OCONEE SKIN CANCER & DERMATOLOGY, LLC  
PAYMENT POLICY**

It is the policy of Athens-Oconee Skin Cancer & Dermatology, LLC to require payment in full ( or co-pay, coinsurance, deductible and balance forward) at the time of each visit. In addition, patients are financially responsible for all charges incurred and other fees not covered by their insurance company (for example, doctor not participating with your insurance network or cosmetic procedures). You will be responsible for a \$25 fee for returned checks plus amount owed. You will be responsible for a \$10 fee for balances owed after 30 days and for a \$28% interest penalty on past due balances turned over to an outside collection agency for recovery.

I acknowledge and understand the payment policies of Athens-Oconee Skin Cancer & Dermatology, LLC. I authorize payment of medical benefits to: Athens-Oconee Skin Cnacer & Dermatology, LLC for services rendered. I authorize release of health information necessary to process claims made by Athens-Oconee Skin Cancer & Dermatology, LLC on my behalf, for services rendered to me. I also certify that the information provided is up-to-date and complete. I ALSO CONSENT TO THE RELEASE OF MY MEDICAL RECORDS TO MY REFERRING PHYSICIAN OR PHYSICIAN I AM REFERRED TO.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_