MISSISSIPPI DERMATOLOGY ASSOCIATES

1006 TREETOPS BLVD., SUITE 101
FLOWOOD, MISSISSIPPI 39232
(601) 939-0005 Fax (601) 936-4949

PATIENT INFORMATION

Patient's Name: First: Middle Initial: Last: Preferred Name:

Mailing Address: City: State: Zip:

Home Phone: ( ) Work Phone: ( ) Cell Phone: ( ) Preferred Phone Number (circle one): H / W / C

Social Security Number: Birth date: Sex: ❑ M ❑ F Marital Status (circle one): Single / Mar / Div / Sep / Wid

Occupation: Employer: Employer address:

Name of Parent or Spouse: Birth Date:

Employer: Work Phone:

Person Responsible for account: Address (if different):

Other family members seen here:

Referring Doctor:

PRIMARY INSURANCE INFORMATION

(Please give your insurance card(s) to the receptionist.)

Policy Holders Name: Birth date: Address (if different): Social Security Number:

Is this person a patient here? ❑ Yes ❑ No

Insurance Company: Policy Number:

Payment required at the time of service? ❑ Co-pay ❑ Percentage How much?

SECONDARY INSURANCE INFORMATION

Policy Holders Name: Birth date: Address (if different): Social Security Number:

Is this person a patient here? ❑ Yes ❑ No

Insurance Company: Policy Number:

Payment required at the time of service? ❑ Co-pay? How much? ❑ Percentage? How Much?

Your signature authorizes payment to the doctor when an assigned claim is filed. It further authorizes the doctor to release medical information necessary to process insurance claims. You hereby agree to be responsible for payment of this account.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **DATE**

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize the office of Mississippi Dermatology Associates to release any information regarding my account, insurance information, laboratory results and medical reports to the following person:

_____	_____
Name of person (other than self) authorized to receive information Example: Father, Mother, spouse, Child, Etc.	For security, please list the authorized person's date of birth

If the patient is a minor, the guardian must sign on behalf of the patient and is allowed to receive any information regarding patient without any other authorization needed. This authorization may be revoked in writing by the patient or personal representative.

May we leave a message on your home answering machine or cell phone? ❑ Yes ❑ No

May we leave a message for you at work? ❑ Yes ❑ No

May we send notices of information about the practice, such as appointment reminders, to your home? ❑ Yes ❑ No

May we use limited data for research, public health, and health care operations purposes, should this ever be requested? This data would only include the following identifiable information: admission, discharge, and service dates, date of death, age (including 90 or over), and five-digit zip code. We would not use name, social security, address, phone number, etc. ❑ Yes ❑ No

_____	_____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY	**DATE**

NOTICE TO PARENTS

Parents often find it difficult to accompany their minor children (under 18 years of age) to routine follow up appointments. This form has been created to give you the opportunity to authorize treatment for your minor child in your absence.

Authorization for Treatment of a Minor

I authorize William Burrow, M.D. or Beau Burrow, M. D. to render treatment to my minor child without my presence in the office.

_____

Patients Name

_____	_____
SIGNATURE OF PARENT OR LEGAL GUARDIAN	**DATE**