MISSISSIPPI DERMATOLOGY ASSOCIATES

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

UPDATED 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):

INSURANCE COMPANY: 1.________________________ POLICY NUMBER:__________________________

2.________________________ POLICY NUMBER:__________________________

COPAY OR PERCENTAGE AT TIME OF SERVICE:________________________

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

May we leave a message for you at: (Please check all that apply) _____Home _____Cell _____Work

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**