SOUTHERN
INSTITUTE OF DERMATOLOGY

2800 Ross Clark Circle, Suite 2
Dothan, Alabama 36301
334-699-7546

Patient Information

Patient Name: ________________________ Today's Date: ______________
Street Address: ________________________ Apt, Lot, Ste #: ___________
City: ________________________ State: __________ Zip: ________
DOB: ______________ Age: ______ Sex: ____ Marital Status: ☐ M ☐ S ☐ D ☐ W
Home Phone #: ____________________ Cell Phone #: ____________________
Employer: ________________________ Work #: ____________________
May we contact you at work? __________ Do you wish phone calls to be confidential? ________
Email: ________________________ May we send information here? __________
SSN: ______________ How did you hear about our practice? ________________
Referring Physician (if applicable): ________________________________
Primary Care Physician: ________________________________

Emergency Contact Information

Contact Name: ______________________ Relationship to Patient: Text__________
Contact Number: __________________ Alternate number: ____________________

Insurance Information

Primary Insurance

Insurance Company: ____________________ Policy ID Number: ________________
Cardholder's Name: ____________________ Relationship to Patient: ______________
Cardholder's DOB: ____________________ Cardholder's SSN: ________________
Cardholder's Employer: ____

Secondary Insurance

Insurance Company: ____________________ Policy ID Number: ________________
Cardholder's Name: ____________________ Relationship to Patient: ______________
Cardholder's DOB: ____________________ Cardholder's SSN: ________________
Cardholder's Employer: ____

I authorize payment of benefits as determined by my insurance carrier directly to the physician. As the responsible party, I agree that I will be responsible for all charges incurred including those amounts not paid by my insurance company. Also, I agree that to my knowledge the above information is the most accurate and up to date. I authorize the release of this information as well as the release of medical records, if necessary, for payment by my insurance carrier. I authorize the use of this signature on all of my insurance submissions whether manual or electronic. I understand I will be charged for, and hereby agree to pay, all costs and expenses incurred in collection, any past due fees, and interest allowed by law, all without relief from valuation and appraisement laws.

Please note, there may be additional costs from outside laboratories. Biopsies, cultures, and other medical specimens will be sent to an outside lab. It is the patient's responsibility to contact their insurance carrier with inquires regarding network coverage for these facilities. Information on these facilities will gladly be supplied to the patient at their request.

Responsible Party Signature: ________________________ Date: ______________