



# DERMATOLOGY ASSOCIATES of GEORGIA

**Patient Name** \_\_\_\_\_  
Last Name First Name Middle Initial Email address

**Address** \_\_\_\_\_  
Street City State Zip Code Apartment #

**Date of Birth** \_\_\_\_\_ **SS #** \_\_\_\_\_ **Sex - F M** **Marital Status - S M W D**

**Home Phone** \_\_\_\_\_ **Work Phone** \_\_\_\_\_ **Cell Phone** \_\_\_\_\_

Circle the best day time number

**Emergency Contact** \_\_\_\_\_ **Relationship** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**May we leave a message if we are unable to reach you?** Y N

**If yes, with whom?** Voicemail \_\_\_\_\_ Spouse \_\_\_\_\_ Other \_\_\_\_\_

**Employer** \_\_\_\_\_ **Occupation** \_\_\_\_\_

**Person responsible for this account if other than self or if patient is a minor.**

**Name** \_\_\_\_\_ **Relationship** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Address** \_\_\_\_\_

**Home Phone** \_\_\_\_\_ **Work Phone** \_\_\_\_\_ **Cell Phone** \_\_\_\_\_

Circle the best day time number

**Employer** \_\_\_\_\_ **Occupation** \_\_\_\_\_

**Insurance - If you plan to use insurance for your medical services, you must present your current card before your visit. Otherwise, you will be asked to pay for services today and file your own insurance claim.**

**Name of insurance Co.** \_\_\_\_\_ **HMO** \_\_\_ **PPO** \_\_\_ **POS** \_\_\_ **OTHER** \_\_\_

**Name of Policy Holder** \_\_\_\_\_

**SS#** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Name of Secondary Insurance Co.** \_\_\_\_\_

**Name of Policy Holder** \_\_\_\_\_

**SS#** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ **Referred by:** \_\_\_\_\_

**How did you hear about us?** M.D. Website Family / Friend Other \_\_\_\_\_

I give my permission for all providers with Dermatology Associates of Georgia, L.L.C. to treat the patient above.

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my provider or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Decatur**  
1951 Clairmont Road  
Decatur, GA 30033  
404-321-4600 • Fax 404-320-0987

**Johns Creek**  
4285 Johns Creek Parkway  
Suite A  
Suwanee, GA 30024  
770-622-4412 • Fax 770-622-4191

**DeKalb Medical Center**  
2665 North Decatur Road  
Suite 650  
Decatur, GA 30033  
404-508-0566 • Fax 404-508-0567

**Piedmont**  
2061 Peachtree Road NE  
Suite 400  
Atlanta, GA 30309  
404-554-0810 • Fax 404-554-0348

**Monroe**  
201 Michael Etchison Road  
Monroe, GA 30655  
770-267-5877 • Fax 770-207-4944