SkinMD
BELLE MEADE | NASHVILLE

MR# **BASIC INFORMATION** Today's date:

Name _____ Preferred Name _____

Home Address_____ City/State _____ ZIP Code _____

Best Daytime Phone Number ( ) _____ Cell Phone Number ( ) _____

Birth Date ___ /___/___ SSN _____ E-Mail_____

Patient Employer Name _____ Phone ( ) _____

Pharmacy Name & Address _____ City _____

Who is your Primary Care Physician? _____City & State_____

Local Emergency Contact: _____ Phone: (__)_____Relationship:_____

Who may we speak to regarding your medical condition?

Contact: _____ Phone: _____ Relationship: _____
Contact: _____ Phone: _____ Relationship: _____

How may we contact/ leave a message for your upcoming appointment reminders:

Phone: yes____ no____ Text: yes____ no____ Email: yes____ no ____

INSURANCE INFORMATION

☐ Yes – I have insurance coverage. Please file to the insurance plan listed below.
☐ No – I have NO insurance coverage and have made payment arrangements.

*Primary Insurance Company Name: _____ Network _____

Employer _____ Policy Holder Name _____ DOB _____/_____/_____
Relationship to policy holder (circle one) Self Spouse Child Other

*Secondary Insurance Company Name: _____ Network _____

Employer _____ Policy Holder Name _____ DOB _____/_____/_____
Relationship to policy holder (circle one) Self Spouse Child Other

RELEASE AUTHORIZATION

I authorize any holder of medical or other information about me to release to any carrier or the Social Security Administration and CMS or its intermediaries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I authorize payment of insurance benefits directly to SkinMD.

HIPAA INFORMATION: Your medical information disclosed will be used and forwarded in order to provide continuing treatment or care, filing your claims, and all other healthcare operations only.

Patient/Guardian Signature _____ Date _____

Print Name _____ Date of Birth _____