WELCOME TO SKINTRUST DERMATOLOGY

ERIC J. BAKER, M.D. P.A.

PLEASE PRESENT INSURANCE CARD, DRIVERS LICENSE OR PHOTO I.D. TO THE RECEPTIONIST– PLEASE PRINT

Full Name (Last)_____(First)_____(MI)_____ Date _____/_____/_____

Mailing Address_____(City)_____(State)_____(Zip)_____

Social Security #_____ Date of Birth _____/_____/_____ Sex: M F Marital Status S M D W

Home Ph#_____ Cell #_____Email: _____

Emergency Contact _____Relationship _____Ph #_____

Patient's Employer_____ Occupation_____ __Work Ph#_____

RESPONSIBLE PARTY INFORMATION

Name_____Address_____(City/St/Zip)_____

Birthdate_____/_____/_____ Social Security #_____ Ph#_____

Employer:_____Occupation:_____Relationship to Patient:_____

***PRIMARY MEDICAL INSURANCE*:**_____ Subscriber Name:_____

Date of Birth _____/_____/_____Group#_____ ID#_____

***SECONDARY MEDICAL INSURANCE*:** _____Subscriber Name:_____

Date of Birth _____/_____/_____Group#_____ID#_____

ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE INFORMATION/HIPPA

I/We hereby authorize Eric J. Baker, M.D. P.A. to release any medical or incidental information that may be necessary for medical benefit or in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration, and Worker's Compensation. This assignment of benefits will remain in effect until revoked by me in writing. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

CONSENT FOR TREATMENT: I/We hereby authorize Eric J. Baker, M.D. P.A. to administer diagnostic and medical procedures as may be necessary for proper health care.

OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be filed for me. It is my responsibility to pay any deductible, copay or any other balance not paid for by my insurance company at the time of my visit. I authorize insurance benefits to be paid directly to Eric J. Baker, M.D. P.A.

DO WE HAVE YOUR PERMISSION TO: Discuss your medical condition with a member of your household? _____YES _____ NO

If yes, whom_____Relationship:_____Ph#_____

BY SIGNING BELOW: I acknowledge the information on this form to be accurate and correct.

Signature **(Patient or Authorized Person) _____Date:_____**

How did you hear about our practice?_____