MURFREESBORO DERMATOLOGY CLINIC, PLC

Michael W. Bell, M.D. & Associates

Today's Date_____

PATIENT INFORMATION

_____

First Middle Last

Mailing Address_____

City/State/Zip_____

Sex _____ Home Phone_____

Employer's Name _____

Work Phone _____ Ext_____

Cell Phone_____ Marital Status_____

Student: Y or N School:_____

Date of Birth_____ S.S. #_____

RESPONSIBLE PERSON (if other than patient)

_____

First Middle Last

Mailing Address_____

City/State/Zip_____

Relation to Patient _____

Home Phone _____ S.S.#_____

Work Phone _____ Ext._____

Date of Birth_____

PRIMARY INSURANCE

Policy Holder Name _____ Policy Holder's Date of Birth_____

Address (if different) _____

Phone Number (H):_____ (W):_____ Cell:_____

Relationship to Patient: Self Spouse Parent Other :_____

Employer's Name : _____ Copay Amount $_____

Identification # _____ Soc. Sec. # (if different) _____

Insurance Carrier Name : _____ Group#_____

Address: _____

SECONDARY INSURANCE

Policy Holder Name _____ Policy Holder's Date of Birth_____

Address (if different) _____

Phone Number (H):_____ (W):_____ Cell:_____

Relationship to Patient: Self Spouse Parent Other :_____

Employer's Name : _____ Copay Amount $_____

Identification # _____ Soc. Sec. # (if different) _____

Insurance Carrier Name : _____ Group#_____

Address: _____

PHYSICIAN INFORMATION

Was this visit set up by a physician's office or did your doctor ask you to see us? Yes No

Physician Full Name:_____ Office Telephone No._____

Street Address:_____ City, State, Zip_____

(continued on back)

May we leave personal medical information on your answering machine at home? Yes No

May we leave personal medical information on your answering machine at work? Yes No

May we e-mail personal medical information to you? (e.g. prescription refills) Yes No

e-mail address:_____

By signing this consent, I understand that any Confidential Health Information that I send to the practice is not secure and is sent at my own risk. I will not hold the practice, nor any of its workforce members, liable for loss of any confidentiality associated with information transmitted via e-mail. I also understand that it is not the policy of this practice to encrypt any Confidential Health Information I request to be sent to me via e-mail. Because it is not encrypted, I understand that it is not secure. I acknowledge the risk and will not hold the practice or any of its workforce members liable for any loss of confidentiality associated with such transmissions.

Do you give our office permission to discuss medical information with family members? Yes No

Name:_____ Relationship:_____

Home Phone_____ Other:_____

Name:_____ Relationship:_____

Home Phone:_____ Other:_____

In case of an emergency, whom should we notify?_____

Relationship to Patient:_____ Phone:_____

AUTHORIZATION & CONSENT

I authorize my insurance company(ies) to pay benefits directly to my provider. I hereby consent to the release of medical information, including electronic means, necessary to process any insurance claims and to any other doctor for the continuation of my medical care. The information I have provided above is accurate to the best of my knowledge. I accept personal responsibility for any and all services in which I have been proven ineligible for medical benefits. I have read and received "Information Regarding Insurance & Billing." I understand a photocopy of this release is as valid as the original. You may receive a signed copy upon your request.

_____ _____

Signature of Patient Date

NOTICE OF PRIVACY PRACTICES RECEIPT

I have (please choose one):

____ received a copy of Murfreesboro Dermatology Clinic's Notice of Privacy Practices.

____ been offered a copy of Murfreesboro Dermatology Clinic's Notice of Privacy Practices but do not want a copy.

_____ _____

Patient's Signature (or Guardian if under 18) Date

Please read and sign the *Information Regarding Insurance & Billing* notice on the following page.