BELLE MEADE DERMATOLOGY
Laser & Aesthetic Center

MRN#_____ Today's Date____/____/____

PATIENT INFORMATION

(Please Print) Name _____ (_____)
Last *First* *M.* *Nickname*

SS#_____ - ____ - _____ Date of Birth ____/____/____ Age____ Gender ☐ M ☐ F Marital Status _____

Home (Billing) Address _____

City_____ State_____ Zip_____

Cell (_____) _____ - _____ Home (_____) _____ - _____ Email _____

Your Employer _____ Work Phone (_____) _____ - _____

Spouse Name _____ Date of Birth ____/____/____

Spouse's Employer _____ Work Phone (_____) _____ - _____

Person Financially Responsible for this Account: _____ Relation to patient _____

Responsible Party's Birthdate _____ Address _____Phone _____

Please check whom you are seeing:

☐ Chris C. Pardue, M.D. ☐ T. Wayne Day, M.D. ☐ K. Dawn Vincent, M.D.
☐ Jerry "Jay" Smith, M.D. ☐ Margaret Morgan, N.P. ☐ Jennifer Warren, N.P.

PLEASE COMPLETE POLICY HOLDER INSURANCE INFORMATION:

Primary Insurance Company _____
Name of Policy Holder _____
Policy Holder's SS# _____
Policy Holder's Date of Birth _____
Relationship of patient to the insured_____
Address (If Different) _____
Phone (If Different)_____

Secondary Insurance Company _____
Name of Policy Holder _____
Policy Holder's SS# _____
Policy Holder's Date of Birth _____
Relationship of patient to the insured_____
Address (If Different) _____
Phone (If Different)_____

Preferred Pharmacy_____ Phone (_____) _____ - _____

Primary Care Physician _____ Phone (_____) _____ - _____

I may be contacted by the clinic at (check all that apply): ☐ home ☐ cell ☐ work ☐ text ☐ email

Messages regarding health information may be left on an answering machine? ☐ yes ☐ no

Would you like an appointment reminder (☐ yes ☐ no) sent to you by: text (_____) _____ - _____
OR
phone call (_____) _____ - _____

In case of an emergency, who should be notified? _____Phone (_____) _____ - _____

How did you hear about us? ☐ advertisment ☐ internet ☐ referred by_____ ☐ other _____

CONTINUED ON REVERSE SIDE

MEDICAL HISTORY

— check all that apply —

☐ anemia	☐ gastrointestinal disorder	☐ high blood pressure	☐ psoriasis
☐ arthritis	☐ heart attack	☐ irregular heart beat	☐ seizures
☐ blood clot	☐ heart murmur	☐ **joint replacement**	☐ stroke
☐ cataracts/glaucoma	☐ **heart valve replacement**	☐ liver	☐ thyroid
☐ **diabetes**	☐ **hepatitis B or C**	☐ lupus	☐ tuberculosis
☐ eczema	☐ **HIV**	☐ pacemaker/defibrillator	

Skin cancer? ☐ yes ☐ no Indicate type: ☐ basal cell carcinoma ☐ squamous cell carcinoma ☐ melanoma

Do you have a history of atypical moles? ☐ yes ☐ no

Cancer other than skin cancer? ☐ yes ☐ no If yes, what type? _____

FEMALES ONLY

Are you currently pregnant? ☐ yes ☐ no Currently breastfeeding? ☐ yes ☐ no

CURRENT MEDICATIONS: (including over the counter)

1. _____ 2. _____ 3. _____ 4. _____

5. _____ 6. _____ 7. _____ 8. _____

Are you on any blood thinners? If yes, what are you taking? _____

MEDICATION ALLERGIES: 1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____ 7. _____

SOCIAL HISTORY:

Do you drink alcohol? ☐ yes ☐ no

Do you smoke? ☐ yes ☐ no

Receipt of Notice of Privacy Practices:

A copy of the Belle Meade Dermatology Notice of Privacy Practices has been made available to me while in the office today. Should I choose to have a personal copy, one will be given to me at no charge.

- ☐ I have read, understand and acknowledge the Privacy Practices of Belle Meade Dermatology.
- ☐ I have elected not to read the Privacy Practices of Belle Meade Dermatology.
- ☐ A copy of Belle Meade Dermatology's Privacy Practices was given to me today.

I hereby authorize the following person(s) to have access to my financial and medical records.

1. _____ relation to patient _____

2. _____ relation to patient _____

3. _____ relation to patient _____

I hereby authorize consent to Belle Meade Dermatology for treatment, release of medical information necessary to process claims, and for general health care operations. It is my responsibility to advise this office of any changes to my personal information at the time of service. I understand my insurance carrier may not approve or reimburse my medical services in full due to benefit exclusions, coverage limits, lack of authorization, or medical necessity. I am responsible for non-covered services, co-pays, deductible, and co-insurance cost. We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us, including phone calls, text messages, and emails. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing. If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer fees which we incur plus all court costs. In case of suit, you agree the venue shall be Davidson County, Tennessee. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.

_____ _____

Signature of patient, or parent, or responsible party Date