M.D. CLAIBORNE & ASSOCIATES, L.L.C.

PATIENT INFORMATION FORM

Section I-Patient Information

Name:_____
(please print full name - no nicknames)

Address:_____

City:_____ State:_____ Zip code:_____

Home number ( )_____-_____ Cell phone ( )_____-_____

Email address: _____@_____

SSN:_____-_____-_____ Date of Birth:_____/_____/_____

Gender: (please circle one) Male | Female

Marital Status: (please circle one) Single | Married | Widowed | Divorced

Race: ____White (non Hispanic) ____Hispanic ____Asian
____American Indian ____Indian ____African American
____Other _____

Employer:_____ Occupation:_____

Work number ( )_____-_____ Work Email: _____

If referred, by whom: _____

Primary Language: _____
Please note that this office uses English as its primary language. We do not offer any interpreter or translation services. If you require an interpreter, you must provide one for yourself prior to medical treatment.

Section II-Minors

Parent/Guardian Name: _____ relationship to patient: _____
Address and telephone the same? ____Yes ____ No
If not, address for parent/guardian:
Address:_____

City:_____ State:_____ Zip code:_____

Home number ( )_____-_____
Please note that children under the age of 18 must be accompanied by a parent or guardian at all visits.

Section IV-Insurance

For medical record purposes, please present all current unsurance cards to Front Desk for verification and scanning.

Are you covered by more than one carrier? (please circle one) Yes | No
If so please tell us which is: primary_____ secondary _____
Insurance holder's name:_____
Insurance holder's date of birth:_____/_____/_____
Insurance holder's SSN:_____-_____-_____

Section IV-Authorizations

Do you give permission for our office to discuss your medical information with family members? (please circle one) Yes | No
If yes, then tell us with whom:
Name:_____ relationship _____ phone # _____
Name:_____ relationship _____ phone # _____
Emergency contact name: _____ relationship _____
Home number ( )_____-_____ alternate number ( )_____-_____

May we leave personal medical information on your answering machine or cell phone? (please circle one) Yes | No

How would you like to be addressed from the waiting room? (please circle all that apply) Full Name | Last Name | First Name

How may this office contact you in regards to appointments, treatment, billing? (please circle all that apply) Cell Phone | Home Phone | Work Phone | Email | Test | All methods

Section IV-Office Policy

Financial -	It is the policy of this office to collect all co payments due at the time of the service. If a balance is due on your account, we will send you a statement for that balance. A total of only **2** statements will be sent. If no payment is received after the second notice, your account will be placed with an outside collection agency for settlement.

Appointments -	This office is operated on an appointment only basis. We do not accept walk ins. Your time is just as important as ours. If you are more than 15 minutes late for your scheduled appointment, we ask that you reschedule as a courtesy to others. If you need to cancel an appointment, please call as soon as possible to les us know. Patients who continually do not show for their scheduled appointments without calling to cancel, will be asked to find care with another dermatologist. You will be sent a certified letter informing you of this decision.

HIPAA -	We will protect your right to privacy as outlined by the HIPAA laws. Brochures are available throughout this office for your convenience. By signing below, you agree that you understand your rights under this policy.

Assignments -	You agree to have all insurance payments sent directly to the doctor performing your service(s). We will file all charges as a courtesy for you to your carrier. There are times when medical information will be requested by your carrier in order to verify and process your charge(s). By signing below, you grant us the right to send this information on your behalf so that your charges may be settled.

HIPAA - Assignments -	It is the policy of this office to collect all co payments due at the time of the service. If a balance is due on your account, we will send you a statement for that balance. A total of only **2** statements will be sent. If no payment is received after the second notice, your account will be placed with an outside collection agency for settlement.

Tumor Registry-	This office is mandated by law to record any malignant lesions with the Louisiana Tumor registry. The information is protected under your HIPAA rights and is not forwarded to any other agency. By signing below you agree to allows us to record this information should it apply to you.

_____ _____

Patient Signature Date