Herron & Bodiford Dermatology & Laser

Patient Registration Form

Patient: _____ DOB: _____ Age: _____

Address: _____ City: _____ Zip Code: _____

Home #: _____ Cell #: _____ Cell Phone Company: _____

Social Security # _____ Sex: M / F Marital Status: M S D W Race: _____

Employer: _____ Phone: _____

Referring Physician: _____ Phone: _____

Patient or Parent E-Mail: _____

Parent / Guardian Information

Parent / Guardian Name: _____ DOB: _____

Home #: _____ Cell #: _____

Employer: _____ Work #: _____

Name of Spouse: _____ DOB: _____ Phone #_____

Name of Insurance Company: _____

Name of Policy Holder: _____ DOB: _____

Policy Holder SS#: _____ Relationship to Patient: _____

Pharmacy Name: _____ Phone #_____ Location: _____

Emergency Contact: _____ Phone # _____

Under the privacy notice of Herron & Bodiford Dermatology and Laser, I understand that the physicians / staff will not discuss my health information with family or friends unless I authorize them to do so. I hereby authorize the physician / staff to only convey information about my health to the following people.

Name: _____ Relationship: _____ Phone# _____

Name: _____ Relationship: _____ Phone# _____

I give permission for physicians / staff, and / or agents to contact me at any of the following:

Cell: Yes / No **Home:** Yes / No **Answering Machine:** Yes / No **Employer:** Yes / No

(Continued on back)

Consent for Treatment / Medical Photography

I consent and authorize my provider(s) or designee(s) to provide diagnostic and therapeutic treatment, which may include biopsy, cryosurgery, laser and prescription medications.

I consent to the taking of photographs during the course of treatment. These photographs will remain in the medical records. Photographs may be shared with consulting physicians if medically necessary.

I certify that I have been given the opportunity to ask any questions and that I have read and fully understand the contents of this consent form.

Patient's Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

Payment Policy

All copay's and/or deductibles are due at time of visit. We do not bill copays. If unable to pay, we will be happy to reschedule your appointment. I agree to be financially responsible for any and all charges for services rendered by Mark D. Herron, MD, Katherine Bodiford, MD and Kelli Riddle, PAC. I also understand that if payment is not made I will be responsible for any attorney fees and/or collection costs.

In order for us to service your account or to collect monies you may owe, Herron & Bodiford Dermatology and Laser and/or our agents may contact you by phone at any number associated with your account, including cell phone numbers, which could results in charges to you. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing services as applicable.

I/We have read this disclosure and agree that Herron & Bodiford Dermatology and Laser, its employees and/or agents may contact me/us as described above.

Patient's Signature / Parent/Guardian: _____ **Date:** _____

By my signature below, I acknowledge that I have received the Privacy Notice of Mark D. Herron, MD

Patient's Signature / Parent/Guardian: _____ **Date:** _____