4201-200 Lake Boone Trail
Raleigh, NC 27607
(O) 919/ 782-2152
(F) 919/ 782-7929

SOUTHERN DERMATOLOGY

SKIN CANCER CENTER
SKIN RENEWAL CENTER

Gregory J. Wilmoth, MD
Eric D. Challgren, MD
Margaret B. Boyse, MD
Laura D. Briley, MD
Tracey S. Cloninger, PA-C

PATIENT INFORMATION FORM

Today's Date: _____ DOB: _____ Account #: _____

Last Name: _____ First Name: _____ M.I.: _____

Mailing Address: _____
City, State, Zip: _____

Physical Address (no PO boxes): _____
City, State, Zip: _____

Primary Phone #: _____ Secondary Phone #: _____
SS # (optional): _____ Email Address: _____
Gender: ☐ Male ☐ Female Religious Affiliation: _____ Race: _____
Emergency Contact Name: _____ Phone #: _____

Primary Care Physician Name: _____ Phone #: _____
Referring Care Physician Name: _____ Phone #: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Policy Holder's Name: _____
If NOT the patient, provide Date of Birth: _____ Policy Holder's ID/SS#: _____
Name of Employer: _____ Group ID #: _____

Secondary Insurance Company: _____ Policy Holder's Name: _____
If NOT the patient, provide Date of Birth: _____ Policy Holder's ID/SS#: _____
Name of Employer: _____ Group ID #: _____

FINANCIAL RESPONSIBILITY

- I agree to promptly pay for any service(s) provided to me not covered by my insurance policy.
- I agree to pay all copayments, coinsurance, and deductibles, and for cosmetic services, at the time service is rendered.
- I agree to provide at least 1 business day notice to cancel/reschedule an appointment. Failure to do so may result in administrative fees of $25 for office visits, $100 for surgical visits.
- I understand it is my responsibility to verify my insurance company benefits coverage and to obtain any necessary authorizations/referrals/approvals from my insurance company and/or my primary care physician.
- I understand that I am responsible for all/any non-covered services if my insurance does not pay and/or does not participate or contract with Southern Dermatology.
- I understand that filing to my insurance is a courtesy only, and not a guarantee of payment; I am responsible for all services rendered.

_____ _____
Signature of Patient / Responsible Party or Parent / Legal Guardian (If patient is a minor) Date:

CONSENT TO TREAT

I understand my provider & I will discuss and agree on an appropriate treatment plan and I consent to participate in that plan as determined. If patient is a minor presenting for evaluation and/or treatment without an accompanying parent/legal guardian, I hereby give my permission to evaluate and treat the minor patient.

_____ _____
Signature of Patient / Responsible Party or Parent / Legal Guardian (If patient is a minor) Date:

4201-200 Lake Boone Trail
Raleigh, NC 27607
(O) 919/ 782-2152
(F) 919/ 782-7929

SOUTHERN DERMATOLOGY
SKIN CANCER CENTER
SKIN RENEWAL CENTER

Gregory J. Wilmoth, MD
Eric D. Challgren, MD
Margaret B. Boyse, MD
Laura D. Briley, MD
Tracey S. Cloninger, PA-C

PATIENT INFORMATION FORM (CONTINUED)

Last Name: _____ First Name: _____

DOB: _____ Account#: _____

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGMENT

I acknowledge that a copy of the NPP has been made available to me. I understand the NPP is subject to change at any time. I may obtain a revised copy of the NPP upon request.

_____ _____

Signature of Patient/Responsible Party or Parent/Legal Guardian (If patient is a minor) **Date:**

FOR STAFF USE ONLY

Patient declined to sign after NPP was made available. Staff Signature/Witness: _____ Date: _____

AUTHORIZATION TO ACCESS PERSONAL HEALTH INFORMATION

I authorize the following family members, friends or other individuals access to my personal health information. Personal health information (PHI), also referred to as protected health information, generally refers to demographic information, medical history, test and laboratory results, insurance information and other data that is collected by a health care professional to identify an individual and determine appropriate care. Please indicate the individuals and type of PHI you are authorizing the office to release when necessary.

Name: _____ Relationship: _____ ☐ Medical ☐ Financial ☐ Other

Name: _____ Relationship: _____ ☐ Medical ☐ Financial ☐ Other

Name: _____ Relationship: _____ ☐ Medical ☐ Financial ☐ Other

_____ _____

Patient Signature **Date**