



# Dermatology Associates of Georgia, L.L.C

**Decatur Office**

1951 Clairmont Road  
Decatur, GA 30033  
Phone: (404) 321-4600  
Fax: (404) 320-0987

**Johns Creek**

4285 Johns Creek Parkway  
Suite A  
Suwanee, GA 30024  
Phone: (770) 622-4412  
Fax: (770) 622-4191

**Monroe Office**

201 Michael Etchinson  
Rd.  
Monroe, GA 30655  
Phone: (770) 267-5877  
Fax: (770) 207-4944

**Peachtree Corners Professional Center**

5635 Peachtree Parkway  
Suite 270  
Norcross, GA 30092  
Phone: (678) 728-1500  
Fax: (678) 728-1519

## New Patient Form

### New Patient Form Instructions

Dermatology Associates of Georgia, L.L.C. has developed this online New Patient Form to reduce the amount of paperwork that you will have to complete during your first visit, and the amount of time spent waiting for your paperwork to be processed.

Please print this form and complete it by hand; then give your form to one of our staff during your first visit.

If you have any questions concerning the New Patient Enrollment process, then please e-mail us at [FormQuestions@DermGA.Com](mailto:FormQuestions@DermGA.Com) or call us at (404) 321-4600.

### Patient Information

Patient Name: \_\_\_\_\_  
Last Name First Name Middle Initial

Address: \_\_\_\_\_  
Address Line 1  
\_\_\_\_\_  
Address Line 2 City State Zip Code

Date of Birth \_\_\_\_\_ SSN: \_\_\_\_\_ Sex : M F Marital status (circle one):

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ May we leave a message? Y N

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

### Emergency Contact:

Contact Name: \_\_\_\_\_  
Last Name First Name Middle Initial

Phone: \_\_\_\_\_

## Guardian Information

Guardian Name: \_\_\_\_\_  
Last Name First Name Middle Initial

Address: \_\_\_\_\_  
Address Line 1  
\_\_\_\_\_ City State Zip Code  
Address Line 2

Relationship: Self Child Spouse Parent Other: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

## Insurance Information

If you plan to use insurance for your medical services, you must present your current card before your visit. Otherwise, you will be asked to pay for services today and file your own insurance claim.

Primary Insurance Company: \_\_\_\_\_ HMO PPO POS Other: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_  
Last Name First Name Middle Initial

Date of Birth \_\_\_\_\_ SSN: \_\_\_\_\_ Relation: Self Child Spouse Other

Second Insurance Company: \_\_\_\_\_ HMO PPO POS Other: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_  
Last Name First Name Middle Initial

Date of Birth \_\_\_\_\_ SSN: \_\_\_\_\_ Relation: Self Child Spouse Other

## Referral Information

Were you referred to us by a physician? Yes No

Physician Name: \_\_\_\_\_  
Last Name First Name Middle Initial

If No, how did you hear about us? Yellow Pages Website Family/Friend Other: \_\_\_\_\_

## Fee Acknowledgement

Payment of fees: It is the policy of this office that payment is the responsibility of the patient, and payment must be made at the time that services are rendered. However, we will file your claim if we are a participant on your insurance. Laboratory tests performed outside this office will be billed by the participating lab and NOT THIS OFFICE.

I give my permission for all providers with Dermatology Associates of Georgia, L.L.C. to treat the above mentioned patient. By signing my name below, I acknowledge that information on this form is accurate and complete to the best of my knowledge. This information on this form is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my provider or any member of his/ her staff responsible for any errors or omissions that I may have made in the completion of this form.



\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date Signed