



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

Dekalb Medical Office

2665 N. Decatur Road
Suite 650
Decatur, GA 30033
Phone: (404) 508-0566
Fax: (404) 508-0567

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 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