Jayne Fortson MD
Fortson Dermatology & Skin Care Center

Patient Information

Patient Name _____
Last First Middle Initial

SS #: ___ - ___ - ___ Drivers' License #_____State_____

Date of Birth ___ - ___ - ___ Age _____ Gender M F
MM DD YYYY

Email _____ ☐ I prefer not to receive email communications
For Fortson Dermatology & Skincare Center communications. Your information is safe with us.

Mailing Address _____
Street Address Suite/Apartment #

_____
City State Zip

Physical Address _____
If different Street Address Suite/Apartment #

_____
City State Zip

Phone ( ) _____ ( ) _____ ( ) _____
Home Work Cell

Please circle the number you prefer we use to contact you

Do you give us permission to leave detailed voice messages about your care? Y N

_____ ( )
Employer Occupation Phone

Person Responsible for Payment (regardless of insurance)
If Different than Patient

Name _____
Last First Middle Initial

Date of Birth ___ - ___ - ___ SS #: ___ - ___ - ___ Relationship _____
MM DD YYYY

Mailing Address _____
Street Address Suite/Apartment #

_____
City State Zip

Today's Date: _____
MM DD YYYY

Payment & Insurance Information *(please circle which applies to you)*
This office does not bill most private insurance providers.

Self Pay Blue Cross VA Medicaid Medicare

Medicaid # _____ Medicare # _____

Blue Cross # _____ Group # _____

Name of Insured _____ Date of Birth ___-___-_____
(if different than patient) Last First Middle Initial MM DD YYYY

Medications (*please list)*
All medications and supplements Allergies to any medication

Referring Physician or Other Professional

Name_____ (___)_____
Last First Phone (if known)

Emergency Contact
Name_____ (___)_____
Last First Phone
Relationship to You _____

Your Preferred Language _____

Optional Demographic Information *(please circle those which apply)*
Race
Caucasian American Indian/Alaska Native African American Asian
Native Hawaiian/Pacific Islander Other Unspecified

Ethnic Group
Hispanic or Latino NOT Hispanic or Latino Unknown Unspecified

Marital Status
Single Married Divorced Widowed Unspecified

PAYMENT IS REQUIRED AT TIME OF SERVICE. I understand that all fees, regardless of insurance coverage, is the responsibility of the patient and that payment in full is expected at the time of service. I authorize Jayne Fortson, MD, to furnish information to my insurance carriers concerning my illness and treatments. All the information provided above is correct to the best of my knowledge.

A charge of $25 will be made for any cancelled or rescheduled appointments unless notice is given at least 24 working hours in advance.

_____
Signature Printed Name Date