Sun Dermatology Patient Information Sheet
Dr. Jeremy Sunseri & Dr. L. Terry Pynes

Name_____ Date of Birth_____ Sex _____

Mailing Address_____ City_____ State_____ Zip _____

Home Phone_____ Cell Phone_____

Employer _____ Employer Phone #_____

Social Security # _____ Race:_____ Ethnic Group_____

Emergency Contact_____ Emergency Contact#_____

Primary Physician_____ Referring Physician_____

*Primary Insurance_____ ID Number _____

Cardholder's Name_____ Cardholder's SSN #_____

Relationship to Patient_____ Cardholder's Date of Birth_____

*Secondary Insurance_____ ID Number_____

Cardholder's Name _____ Cardholder's SSN # _____

Relationship to Patient _____ Cardholder's Date of Birth _____

Have you ever seen Dr. Sunseri or Dr. Pynes as a patient in the past? _____ Yes _____ No

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices).

Patient or Responsible Party Signature_____ **Date** ____/____/_____

I hereby authorize my insurance benefits, including Medicare, to be paid directly to Sun Dermatology. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not they are paid by said insurance. I hereby Authorize said assigned to release all information necessary to secure that payment. In the event that this account is assigned to collections, I agree to pay all costs of collection including reasonable attorney fees.

PAYMENT POLICY: You will be responsible for paying your annual deductible, co-payment and charges for any non-covered and cosmetic services at the time of service.

PLEASE BE ADVISED: THERE MAY BE ADDITIONAL COSTS FROM AN EXTERNAL LABORATORY IF A BIOPSY OR CULTURE OF ANY KIND IS PERFORMED.

Patient or Responsible Party Signature _____ **Date** ____/____/_____

SUN DERMATOLOGY
MOHS SURGERY | GENERAL | COSMETIC

Dr. Jeremy Sunseri | Dr. L. Terry Pynes

2101 Jenks Ave
Panama City, Florida 32405

Office: (850) 215-3612
Fax: (850) 215-4533

Patient: _____ **Date of Birth:** _____

Please List Any Allergies that You Have:

_____

_____

_____

_____

Patient Medication List - Please list mg and dosing if available

Medication Name	**Dosage/mg**	**How many times daily**

SUN DERMATOLOGY
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Medical Records Release

Please list any and all persons to whom we may disclose your personal health information:

_____ _____

Name Relationship

_____ _____

Name Relationship

For access to your records and results via your **Patient Portal** please provide us with an active email address that we can associate with your Patient Portal. You will receive an email providing you with access upon activation of your account. Email Address:_____

Medication History Consent

I hereby give permission to Sun Dermatology to request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

_____ _____

Name Date

Pharmacy Information

In the event a prescription is needed please list a preferred pharmacy:

Pharmacy Name: _____

Location: _____

Phone: _____

Cosmetics

Would you like to be notified via e-mail or phone about cosmetic events and specials? If so please fill in the information below:

Email Address:_____ Contact Number_____