DERMATOLOGY & DERMATOLOGIC SURGERY CENTER, P.C.

SS#____/____/____ Patient Name _____ Nickname _____
First Middle Last

Home Phone: _____ Additional phone:_____

Home Address _____ Apt #_____
(Please use street address and P.O. Box if needed)

City _____ State _____ Zip Code _____

Sex: Male/Female Date of Birth____/____/_____ Marital Status: M S D W Race: _____

Ethnicity: Hispanic / Non-Hispanic Primary Language: English / Spanish _____

Patient Employer: _____ Work #:_____ Ext: _____

Family Doctor: _____
(Name, Address, and Phone Number)

Person financially responsible for this bill? _____ Relationship? _____

Their SS# _____ Their Address _____

Their Employer _____ Work Phone# _____

Insurance Information

Primary Insurance Name _____ Policy Holder _____

Insurance Address _____ Employer _____

Policy/Group #'s _____ Policy Holder's Date of Birth _____

Secondary Insurance Name _____ Policy Holder _____

Insurance Address _____ Employer _____

Policy/Group #'s _____ Policy Holder's Date of Birth _____

Authorization to Release and Assign Insurance Benefits and No Show Policy

I authorize release of my information to act on this claim and permit a photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to the above medical and or surgical benefits. I am entitled for the above listed services from my Insurance Company. This is to serve as a lifetime authorization. This authorization also applies to the treatment, payment and healthcare operations, as outlined in HIPAA regulations, and also for the RELEASE OF MEDICAL RECORDS to any physician whom I may be referred to by Dermatology and Dermatologic Surgery Center, P.C.

In signing this HIPAA form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

I understand and agree (regardless of my Insurance status) I am ultimately responsible for the balance of my account for any and all services rendered. I certify the information I have provided is true and correct to the best of my knowledge. I will notify you of any changes in my health status or above information.

Appointments need to be cancelled at least 24 hours in advance. I understand that there is a cancellation and/or no show fee charge of $35 incurred after the 2nd occurrence.

Signature: _____ Date: _____

Parent Signature (if minor): _____ Date: _____

☐ I would like a copy of a Notice of Privacy Practices

Meaningful Use Patient Registration:

In compliance with the HITECH Act (EHR) to attain Meaningful Use we are required to capture demographic data including your preferred language, race and ethnicity. This is an important part of your medical history and will assist us during our clinical quality improvement process. Please complete the information below.

Patient Name:_____Date:_____

RACE:

_____African-American
_____Arabic
_____Asian
_____Caucasian
_____Filipino
_____Hispanic
_____Other_____

ETHNICITY:

_____Hispanic
_____Non-Hispanic

PRIMARY LANGUAGE:

_____Arabic
_____Chinese
_____English
_____French
_____Korean
_____Spanish
_____Other_____

VACCINATION: Circle one

Influenza (flu) Vaccination Yes / No
Date:_____
Pneumonia Vaccination Yes / No
Date:_____

TOBACCO USE:

Never:_____
Current Every Day Smoker:_____
Current Smoker-Does Not Smoke Every Day:_____
Former Smoker:_____

Place of Birth:

City: _____
State: _____

Emergency Contact Information

Contact Name_____ Sex – Male / Female

Home # _____ Cell # _____

Patients Relation to Contact _____

Contact Name_____ Sex – Male / Female

Home # _____ Cell # _____

Patients Relation to Contact _____

Do you give Dermatology & Dermatologic Surgery Center permission to discuss your medical information with your Emergency Contact(s)?

□ **Yes** □ **No**

May we leave a message regarding your medical information on your home answering machine?

□ **Yes** □ **No**

Is there a cell phone we may call regarding your personal medical information?

□ **Yes** □ **No**

If yes, Cell Phone Number _____

May we leave a message on your cell phone voicemail regarding your personal information?

□ **Yes** □ **No**

EMAIL: _____

Signature _____ Date _____

Parent Signature (if minor) _____ Date _____