Professional Dermatology Care, PC
Welcome to our Practice!

Patient Information: (PLEASE WRITE CLEARLY-THANK YOU!)

Were you referred? If yes, referring physician name _____

Patient Name:

_____
Last First Middle Initial

Address:

_____
(**NO P.O. Boxes Please**) Apt. # City State Zip

Date of Birth: _____/_____/_____ Home Phone: (_____) _____

Work Phone: (_____) _____ Cell# (_____)_____

PLEASE READ: Please be advised that **not all of our email correspondences are encrypted** and thus, **not secure**. *Therefore, please do not provide us with protected health information via email.* ***Only pathology reports are encrypted and the password can be sent to you via a separate email.*** We want you to be fully aware that our email is unencrypted and if you choose to email us then you assume this risk and then there is no violation of HIPAA rules and regulations. Please be advised that although the information you provide in your email may be privileged and confidential and protected from disclosure, it is unencrypted and subject to breach. **X →** _____***initial***

Responsible Party: (If minor child)

Patient Name: _____Date of Birth: _____/_____/_____
Last First

Address: _____
City State Zip

Home Phone: (_____) _____ Work Phone: (_____) _____ Relationship to patient: _____

Primary Insurance:

Name of Insurance Company: _____

Name of Policy holder: _____ Policy Holder date of birth: _____/_____/_____

Policy / ID #:_____Group #: _____ Relationship to patient _____

Secondary Insurance:

Name of Insurance Company: _____

Name of Policy holder: _____ Policy Holder date of birth: _____/_____/_____

Policy / ID #: _____Group #:_____ Relationship to patient: _____

Emergency Contact Information:

In case of Emergency, who should we notify?_____

Relationship to patient: _____Phone Number: Hm: (_____)_____

Phone Number: Wk: (_____) _____

Phone Number: Cell: (_____) _____

Do you give our office permission to discuss your medical information with your family members?

Yes_____ No _____ if yes, please provide their names and phone number below.

1. Name: _____ Relationship:_____
2. Name: _____ Relationship: _____
3. Name: _____ Relationship: _____

Payment Policy:

We are so small that please understand that payment is due at the time services are rendered whether they are medical or cosmetic. Please remember you are responsible for co-payments, annual deductibles, co-insurances or any other charges that are not covered by your insurance company. Please review all of our policies posted in the exam rooms. Thanks! **X →** _____***initial***

Receipt of Notice of Privacy Practices:

My signature below indicates that I have received and / or reviewed a copy of PDC, PC notice of use and disclosers of notice of privacy practices.

Please Note:

Please review all office policies online at www.professionaldermatologycare.com

X → Patient or Responsible party signature:_____Date____/_____/____