DERMATOLOGY, PLC

PATIENT FULL NAME: _____

First Middle or Maiden Last

PATIENT DATE OF BIRTH: _____

BILLING ADDRESS: _____

Address City State Zip Code

IF PATIENT IS A MINOR: PARENT OR GUARDIAN NAME: _____

EMAIL: _____

PHONE: CELL: _____ HOME: _____WORK: _____

EMPLOYER: _____PRIMARY CARE PHYSICIAN _____

IS IT OK TO LEAVE MESSAGES AT THESE PHONE NUMBERS? _____

PREFERRED PHARMACY: _____ PHARMACY ADDRESS: _____

EMERGENCY CONTACT: NAME:_____NUMBER:_____

INSURANCE CO: _____SUBSCRIBER:_____SUB DOB: _____

DRUG ALLERGIES: _____

CURRENT MEDICATIONS: _____

DO YOU CURRENTLY SMOKE? _____IF NO, DID YOU SMOKE IN THE PAST: _____

HAVE YOU HAD HEPATITIS? Yes or No

HAVE YOU BEEN TESTED FOR HIV? Yes or No HIV TEST RESULTS: _____

I GIVE PERMISSION FOR DERMATOLOGY, PLC TO SPEAK WITH OR SHARE INFORMATION WITH THE FOLLOWING PERSON/PEOPLE: _____

_____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND ANY FUTURE CLAIMS TO MY INSURANCE COMPANY. I ALSO AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO DERMATOLOGY, PLC. I'VE BEEN MADE AWARE THAT THIS OFFICE'S HIPAA NOTICE IS POSTED IN THE WAITING ROOM, AND I MAY REQUEST A COPY.

SIGNATURE_____DATE_____

*******PARENTAL CONSENT FOR CHILD UNDER 18 YEARS OF AGE*******

I AM PRESENT WITH MY CHILD_____ AND I GIVE CONSENT TO DERMATOLOGY, PLC TO SEE AND TREAT MY CHILD AS INDICATED. IF HIS/HER CONDITION REQUIRES FOLLOW-UP, I GIVE PERMISSION FOR CONTINUED OFFICE CARE IN MY ABSENCE (NO INVASIVE PROCEDURES WILL BE PERFORMED WITHOUT DIRECT NOTIFICATION TO THE PARENT/GUARDIAN).

SIGNATURE OF PARENT OR GUARDIAN_____