PREMIER DERMATOLOGY

PATIENT INFORMATION FORM

PATIENT INFORMATION

Name _____ Social Security Number _____

Mailing Address _____City, State_____ZIP_____

Landline Phone _____ Cell Phone _____ Work Phone_____

Date of Birth _____/_____/_____ Age _____ Sex _____

Email Address _____@_____

Ethnicity □Non-Hispanic □Hispanic □Non-Specified Language Preference_____

Race □ African American □ Asian □ Native American □ White □ Other_____

Referred By _____ Primary Care Physician _____

If Under 18: Mother's Name:_____

Father's Name:_____

INSURANCE CARD OWNER OR RESPONSIBLE PARTY
(if different from patient)

Name _____ Sex_____ Social Security #_____

Mailing Address _____

Home Phone _____ Date of Birth _____/_____/_____

In the event of an EMERGENCY, who should be notified? _____

Phone _____ Address _____

Pharmacy_____ **Pharmacy phone**_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been offered a copy of Premier Dermatology's Notice of Privacy Practices:	Yes	No
Can we leave you a DETAILED voice mail message?	Yes	No
If no, can we leave a message with call back info only?	Yes	No
Can we discuss your care and treatment with anyone OTHER than you?	Yes	No

If yes, whom (please include relationship)?_____

Signed _____ Date _____

FOR OFFICE USE ONLY

- □ Individual refused to sign
- □ Communications barriers prohibited obtaining the acknowledgement
- □ An emergency prevented us from obtaining acknowledgement
- □ Other (specify)