# Patient Information

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|---|---|---|---|
| Patient's Name (Last, First, Middle): | | | Date:<br>Home Phone Number: |
| Street Address: | | | Work Phone Number/Extension: |
| City: | State: | Zip: | Cell Phone Number: |
| Male: ☐<br>Female: ☐ | Employed:<br>Yes ☐<br>No ☐ | Student:<br>Yes ☐<br>No ☐ | Email Address: |
| Employer/School Name: | | | Date of Birth<br>/ / |
| Occupation: | | | Patient's Social Security Number |
| Race: ☐ Caucasian ☐ African American ☐ Asian ☐ American Indian ☐ Native Hawaiian/Pacific Islander | | | |
| Ethnicity: ☐ Hispanic or Latina ☐ Not Hispanic or Latina ☐ Declined | | | |
| Preferred Language: ☐ English ☐ Spanish ☐ Indian ☐ Chinese ☐ Korean ☐ Other: | | | |
| Responsible Party: | | | Responsible Party Phone Number: |
| Billing Address if Different Than Above: | | | |
| Referred by your physician?<br>Yes ☐ No ☐ | If yes, Physician's LAST NAME, FIRST NAME: | | |
| Person to notify in an emergency: | Relationship: | | Phone Number: |

## Insurance Information

| | |
|---|---|
| **Primary Insurance Carrier** | Date Completed |
| Group Name or Number | ID # |
| Primary Policyholder's Name (Last, First, Middle Initial) | Date of Birth<br>/ / |
| What is your relationship to the policy holder? Circle One:<br>I am the:<br>Holder ☐ Wife ☐ Husband ☐ Child ☐ | Is a referral required?<br>Yes ☐ No ☐ |

| | |
|---|---|
| **Secondary Insurance Carrier** | Date Completed |
| Group Name or Number | ID # |
| Primary Policyholder's Name (Last, First, Middle Initial) | Date of Birth<br>/ / |
| What is your relationship to the policy holder? Circle One:<br>I am the:<br>Holder ☐ Wife ☐ Husband ☐ Child ☐ | Is a referral required?<br>Yes ☐ No ☐ |

Tidewater DERMATOLOGY

## HOW MAY TIDEWATER DERMATOLOGY CONTACT YOU?

Tidewater Dermatology contacts patients regarding such matters as appointment reminders, insurance items and issues pertaining to clinical care, including laboratory results. Please indicate where we can contact you and if we can leave a message.

| | Provide your phone number below if we may contact you via this number | Check box if we can leave message on voicemail | Please check next to your preferred/primary contact phone number | Check box if we can contact you about cosmetic procedures |
|---|---|---|---|---|
| **HOME** | | | | |
| **CELL** | | | | |
| **WORK** | | | | |

Check the locations where we may send mail:

___ Mail to my home ___ Mail to other: _____

___ May we email you regarding monthly specials or cosmetic procedures? Please note, Tidewater Dermatology will not use or disclose PHI via email.

_____ Email Address

## MAY TIDEWATER DERMATOLOGY DISCUSS YOUR MEDICAL HISTORY WITH ANYONE ELSE?

I authorize Tidewater Dermatology to disclose:

_____ Appointment Information

_____ Information about Cosmetic Procedures

_____ Medical Information/Records

_____ Financial Information

To:

Name of Person or Entity to Receive the Information (e.g. family member, spouse)

This authorization applies to _____ and expires on _____
(Specific or all dates of service) (Date or Defined Event)

I have the right to request that Tidewater Dermatology restrict how it uses or discloses my PHI to carry out TPO. However, the Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

Tidewater Dermatology may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). I have the right to review the Notice of Privacy Practices prior to signing this consent. Tidewater Dermatology reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our Privacy Officer at the above address.

By signing this form, I am consenting to Tidewater Dermatology's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing to the above address except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Tidewater Dermatology may decline to provide treatment to me.

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**Signature of Patient or Legal Guardian** **Date**

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**Patient's Name (Printed)**