Patient Information

PLEASE PRINT CLEARLY

DATE: _________________ EMAIL: __________________________

Name: ____ Male _____ Female _____

Date of Birth: _______________ Age: ______ Social Security #: _________________________________

Address: ______________________________ Apt. #: ___________

City: ____________________ State: ___ Zip Code: _______ Phone: ____________________Home / Cell

Minor ______ Single _____ Married _____ Widower _____

Employer: ______________________________ Occupation: ______________________________

Race: ______________ Ethnicity: _____________ Preferred Language: _______________

IF MINOR, FINANCIAL RESPONSIBLE PARTY

Name: _____________________________________ Relation to patient: ________________________

Date of Birth: ________________ Social Security #: _______________________

Address: ____________________________ Apt. #: ______________

City: ____________________ State: ___ Zip Code: _____ Phone: _____________________Home / Cell

EMERGENCY CONTACT

Name: ___________________________ Relation to patient: ________________ Phone: _____________

PRIMARY INSURANCE

Name of Insured: ____________________________ Date of Birth: _____________ SS#: _____________

Name of Insurance: ______________________________ Employer: _____________________________

ID Number: _________________________________ Group Number: ____________________________

SECONDARY INSURANCE

Name of Insured: ____________________________ Date of Birth: _____________ SS#: _____________

Name of Insurance: ______________________________ Employer: _____________________________

ID Number: _________________________________ Group Number: ____________________________

PAYMENT POLICY: All professional services rendered are charged to the patient. The patient is responsible for payment regardless of insurance coverage. Full payment is expected at time of each office visit unless arrangements have been made in advance. If your account becomes past due, we will take the necessary steps to collect this debt by running your credit card on file. Billing information will be provided to expedite payment reimbursement from private carriers.

AUTHORIZATION OF PAYMENT: I hereby authorize the provider to release medical information concerning my examination and/or treatment for insurance purposes and to receive direct payment for medical benefits payable to me for services rendered.

X ____

Signature of Patient or Parent if Minor Date

1314 E. Sonterra Blvd. Ste. 2201 * San Antonio, TX 78258 * P: (210) 496-5792 | F: (210) 496-7601
2632 Broadway St. * North Building, Suite 201N * San Antonio, TX 78215 * P: (210) 226-0040 | F: (210) 226-0050
www.sonterradermatology.com

Notice and Acknowledgment

I acknowledge that I have received a brochure providing the following information and have been given the opportunity to read and ask questions to assure that I understand their contents. I understand that by signing this form, I consent to the provisions of my patient rights, patient responsibilities and the sharing of information as indicated by the Notice Of Privacy Practices.

- ✓ **Notice of HIPAA Privacy Practices**
  - ✓ **Patient Responsibilities**
    - ✓ **Patient Rights Regarding Health Information**

Printed Name of Patient/guardian Date

____ _______________

Signature of Patient/guardian Date

____ _______________

1314 E. Sonterra Blvd. Ste. 2201 * San Antonio, TX 78258 * P: (210) 496-5792 | F: (210) 496-7601
2632 Broadway St. * North Building, Suite 201N * San Antonio, TX 78215 * P: (210) 226-0040 | F: (210) 226-0050
www.sonterradermatology.com

Please list the family members or other persons, if any, with whom we may discuss your general medical condition and / or diagnosis:

Name: ____ **Phone:** __________________________

Name: ____ **Phone:** __________________________

Name: ____ **Phone:** __________________________

Please print the telephone number and email address where you want to receive calls about appointments, lab or test results, billing, insurance inquiries, or other healthcare information:

Email: ____

Phone: ____________________________

May confidential messages (appointments, labs or test results, billing, insurance inquiries) be left on the email address or answering machine / voicemail of the telephone number provide above.

YES____ **NO ____**

I understand that this agreement remains in effect until revoked by me in writing. If I revoke my consent, such revocation will not affect my actions that Sonterra Dermatology took before receiving my revocation.

____ __________________

Patient or Legal Representative Signature **Date**

____ __________________

Guardian Signature if Patient Under 18 years of Age **Date**