

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: _____

Name of Insurance: _____

ID Number: _____ Group Number: _____

SECONDARY INSURANCE

Name of Insured: _____ Date of Birth: _____

Name of Insurance: _____

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

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 ensure 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

Please list the family members or other people, 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 provided 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