

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ - _____ Cell (____) _____ - _____ Work (____) _____ - _____

DOB ____/____/____ Social Security Number ____-____-____ Male ____ Female ____

Marital Status _____ Occupation _____ Employer _____

Work Address _____ City _____ State _____ Zip _____

Primary Care Physician _____ Were you referred by s/he? Yes ____ No ____

If referred by a friend/relative, who were referred by? _____

If patient is a minor, who is the parent/legal guardian? _____

Emergency Contact _____ Relationship _____ Phone(____) _____ - _____

By signing below, I request payment of insurance/Medicare benefits to be made on my behalf to Northern California Dermatology Center, Inc. I am authorizing any necessary medical information to be released to my insurance/Medicare to pay a claim. I understand that I am responsible financially for any deductible, co-insurance, or non-covered services.

Patient/Parent/Guardian

Date

HIPAA Acknowledgment

By signing below, you are acknowledging that you have had an opportunity to review, if desired, this practice's "Notice of Privacy Practices."

Please mark which phone number(s) we can use to leave messages identifying this practice.

Home ____ Cell ____ Work ____

Please mark which phone number(s) we can use to leave laboratory/biopsy results or other care issues.

Home ____ Cell ____ Work ____

To whom, if anyone, may we disclose laboratory/biopsy results or other care issues?

Name _____ Relationship _____ Phone(____) _____ - _____

Patient/Parent/Guardian

Date