DATE: _____

PATIENT INFORMATION

Name: _____ (Last) _____ (First) _____ (MI)

Address: _____ _____ (City) _____ (State) _____ (Zip)

Telephone: _____ (Home) _____ (Work) Ext: ___ _____ (Cell) Email: _____

Date of birth: _____ Age: _____ Gender: _____

What is your preferred method of contact: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email

Driver's License #: _____ Pharmacy & phone # for prescriptions: _____

Emergency contact: Name _____ Phone _____ Relationship to patient: _____

RESPONSIBLE PARTY (ONLY IF DIFFERENT FROM PATIENT, ABOVE)

Name: _____ (Last) _____ (First) _____ (MI)

Address: _____ _____ (City) _____ (State) _____ (Zip)

Telephone: _____ (Home) _____ (Work) Ext: ___ _____ (Cell) Email: _____

What is your preferred method of contact: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email

Driver's License #: _____

Other family members that are patients: _____

Do you authorize us to discuss your medical care or test results with any family members? If yes, whom: _____

Primary care physician: _____ Phone #: _____

Referring physician (if any): _____ Phone #: _____

PATIENT AUTHORIZATIONS – PLEASE CHECK EACH SPECIFIC STATEMENT FOR WHICH YOU GIVE CONSENT AND SIGN BELOW

☐ I authorize the release of medical information to my primary care or referring physician, or to medical consultants if necessary. Released information may include prescriptions and pathology evaluations.

☐ I consent to medical photographs being taken for the specific purpose of monitoring a lesion or condition.

☐ I consent to photographs being shared with appropriate medical consultants when medically recommended.

Signature (type name, or print and sign): _____ Date: _____

PAYMENT

I acknowledge that Piney Point Dermatology does not accept insurance and agree to make payment for all services when rendered. Acceptable forms of payment include cash, credit cards or checks ($25.00 charge for returned checks). No-shows or same-day cancellations are subject to a $60 charge.

Signature (type name, or print and sign): _____ Date: _____