School Street Dermatology

Patient Information

Today's Date: **Please Answer All Questions** **Please print**- black ink only

Patient's Name:_____

(Last) (First) (Middle initial)

Patient's Age:_____ **Sex:**_____ **Date of Birth:**_____

[Home] Street Address:_____

Preferred Contact Number:_____ **Mobile/home/work**

Does the office have permission to leave you messages?

Can we leave messages with any person other than yourself? **Y/N** *(please circle)*

If yes, whom_____

Email address:_____

Does the office have permission to send you emails? **Y/N** *(please circle)*

Marital Status: (please circle) Married/Single/Divorced/Separated

Occupation:_____ **Business/School Name:**_____

Emergency Contact: (name & relationship)_____

Emergency Contact preferred number:_____

Primary Care Physician:_____ **Phone #**_____

Who were you referred by?_____

Does the office have permission to share your medical record with anyone other than yourself? (Example, spouse, child, relative) **Y/N** *(please circle)*

If yes, whom? (Please list full name and their relationship to you)

_____

I authorize the release of all my medical and surgical information to all my insurance companies.I understand that I am financially responsible for any balance not covered by my medical insurance. A photocopy of this assignment shall be as valid as the original.

_____

Signature & Print of Patient or Guardian Date

Our privacy policy is located in the waiting room for you to read. If you would like a copy please ask the receptionist.