Welcome to Affiliated Dermatologists, S.C. Patient Registration

Date: _____ Acct#: _____ _____
(Office Use) *(Provider)*

Name: _____
Last First Middle

Address: _____
Street City State Zip

Age: _____ **Birthdate:** _____ **Social Security #:** _____

Patient's Employer: _____ **Work Phone:** _____

Home Phone: _____ **Cell Phone:** _____

What is the **PRIMARY** phone number? (**check one**) ☐ **Home** ☐ **Work** ☐ **Cell**

Reminders by **(**check **all** that apply**):** ☐**Phone** ☐**Text** ☐**Email**_____

In case of **Emergency**, notify _____ **Phone:** _____

Relationship to patient: _____

Parent, Spouse, or Responsible Party (*if different from patient*)

Name: _____

Address: _____
Street City State Zip

Home Phone: ( ) _____ Work Phone: ( ) _____

HIPAA permissions authorized by patient:

Do you give our office permission to discuss your medical information with others? ☐ **YES** ☐ **NO**

If yes, please provide their name, relationship, and phone number:

Name:_____ Relationship:_____

Daytime phone:_____ Evening phone:_____

May we leave personal medical information on your answering machine/voicemail? ☐ **YES** ☐ **NO**

If yes, please provide the phone number where we can leave information:_____

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Name: _____
Last First Middle

PLEASE CHECK BOX FOR RACE	PLEASE CHECK BOX FOR ETHNICITY	PLEASE CHECK BOX FOR PRIMARY LANGUAGE
☐ African American or Black	☐ Hispanic or Latino	☐ English
☐ Asian	☐ Non-Hispanic/Non-Latino	☐ Chinese
☐ Caucasian	☐ Other	☐ Spanish
☐ Native American	☐ Patient Declined	☐ Other
☐ Other		☐ Patient Declined
☐ Patient Declined		

AFFILIATED DERMATOLOGISTS, S.C. HIPAA PATIENT CONSENT FORM

- *Protected health information may be disclosed or used for treatment, payment, or health care operations*
- *The Practice has a Notice of Privacy Practices with Addendum; and the patient has the opportunity to review this Notice*
- *The Practice reserves the right to change the Notice of Privacy Practices*
- *The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions*
- *The patient may revoke this Consent in writing at any time and all future disclosures will then cease*
- *The Practice may condition receipt of treatment upon the execution of this Consent.*
- ***HIPAA permissions authorized on registration page 1***

This Acknowledgment/Consent was signed by:

_____
Signature of Patient or Legal Representative / Date

_____
Printed name of Legal Representative, if other than Patient / Relationship to Patient

In the event you default on your account balance, the account will be forwarded to a collection agency.