

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 #:** _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____

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

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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Acct #: _____
(Office Use) (Provider)

Name: _____
Last
First
Middle

PLEASE CHECK BOX FOR RACE

- African American or Black
- Asian
- Caucasian
- Native American
- Other
- Patient Declined

PLEASE CHECK BOX FOR ETHNICITY

- Hispanic or Latino
- Non-Hispanic/Non-Latino
- Other
- Patient Declined

PLEASE CHECK BOX FOR PRIMARY LANGUAGE

- English
- Chinese
- Spanish
- Other
- 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.