DERMATOLOGY ASSOCIATES OF OAK RIDGE, P.C.

website: www.dermor.net

PATIENT INFORMATION

NAME (Last, First, Middle)	SS#	BIRTHDATE	SEX

LOCAL ADDRESS	CITY, STATE, ZIP

HOME PHONE	WORK PHONE	ALTERNATE PHONE (CELL)	MARITAL STATUS ❑ M ❑ S ❑ W ❑ D

REFERRING PHYSICIAN	PRIMARY CARE PROVIDER

PRIMARY EMPLOYER	CITY, STATE, ZIP	SPOUSE NAME

EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE NUMBER

WHO MAY WE DISCUSS YOUR HEALTH INFORMATION WITH?
❑ NO ONE OTHER THAN SELF ❑ SPOUSE ❑ PARENT ❑ VOICEMAIL (Cell, Home) ❑ OTHER (Name)_____

MAY OUR OFFICE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE/VOICE MAIL? ❑ AT HOME ❑ AT WORK ❑ ON CELL PHONE

IF UNABLE TO REACH YOU, WHO IF ANYONE MAY WE RELEASE MEDICAL AND/OR BILLING INFORMATION TO?

_____
(Name) (Phone Number) (Relationship)

BY PROVIDING YOUR EMAIL ADDRESS HERE _____ YOU AUTHORIZE DERMATOLOGY ASSOCIATES OF OAK RIDGE, PC TO EMAIL INFORMATION (PROMOTIONAL SPECIALS).

RESPONSIBLE PARTY INFORMATION (for minor patients)

NAME (Last, First, Middle)	SS#	BIRTHDATE	SEX

ADDRESS	CITY, STATE, ZIP

HOME PHONE	DAY PHONE	MARITAL STATUS	RELATIONSHIP TO PATIENT

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY			NAME OF INSURED (Policyholder)	
SSN	DOB	SEX	RELATIONSHIP TO PATIENT	
ADDRESS (if different from patient)			CITY, STATE, ZIP	PHONE

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY			NAME OF INSURED (Policyholder)	
SSN	DOB	SEX	RELATIONSHIP TO PATIENT	
ADDRESS (if different from patient)			CITY, STATE, ZIP	PHONE

AUTHORIZATION FOR CONSENT TO TREATMENT

I consent to treatment and to the use or disclosure of my protected health information by Dermatology Associates of Oak Ridge, PC for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills and to conduct the healthcare operations of Dermatology Associates of Oak Ridge, PC as may be deemed necessary or desirable by my physician, their assistants and designees. This authorization includes, but is not limited to, evaluation, routine diagnostic procedures, laboratory tests and operative procedures.

I hereby authorize Dermatology Associates of Oak Ridge, PC to release any medical information to my contacts listed. I hereby authorize Dermatology Associates of Oak Ridge, PC to leave messages regarding my appointments and balance notices on my voice mail, answering machine and e-mail as indicated above. I authorize Dermatology Associates of Oak Ridge, PC to send me information and/or promotional specials to my e-mail address.

I hereby authorize Dermatology Associates of Oak Ridge, PC to release any medical information to my referring and/or family doctor, and any insurance that is necessary to process and consider in health insurance claims. I assign to the doctor all payments for medical services rendered, for which Dermatology Associates of Oak Ridge, PC participates. I understand that I am financially responsible for all charges, whether or not covered by insurance.

I consent to the use of photography which may be used to document the nature of a skin disorder, for the future identification of treatment sites, or documentation to insurance companies and referring physicians/practitioners.

I acknowledge receipt of the Notice of Privacy Practices effective April 15, 2003 from Dermatology Associates of Oak Ridge, PC.

_____ _____
Patient, Parent/Legal Guardian, or Power of Attorney Signature Date