

## GENERAL PATIENT INFORMATION

Date of Bathth:   Maniful Statute S M W D   Sex Adolgreed at Bathti:   Mather   Ingel Sex Same as sex assigned at birth:   Tris   Index Address	Patient Name:		Preferred Name:		
Check Perferred Contact Methods:   Intome Pitone       CelPhone:     Consent to Text:   Pro     Prone	Date of Birth: Marital Sta	tus: S M W D Sex Assigned at	 : Birth: ☐ Male ☐ Fema	le Legal Sex: Same as sex assi	igned at birth Yes No
Consent to Text.   Preferred Contact Method   Home Phone     Cell Phone   Consent to Text.   Pres   No.					
Final Address: Details and events only generated by the practice administrator. Email address has he work to communicate health content, particle nearwhy. Comments (petals and events only generated by the practice administrator. Email addresses are kept securely within our practice management system only.)					
news, connectic specials and events only generated by the gractice administrator. Email addresses are kept securely within our practice management system only.)  Phone:    Phone:   Phone:   Specialist Physician who referred you:   Town:   Phone:   Phone:   Phone:   Specialist Physician who referred you:   Town:   Phone:   Pho					
paedalist Physician who referred you:					
Tower   Priority   P	Primary Care Physician:		_Town:	Phone:	
Race:   White   American Indian or Alaska Native   Asian   Black or African American   Native Hawaiian or Other Pacific blander:   Perferred Pronounce   Hispanic or Latino   Not Hispanic or tatino   Not Hispanic or tatino   Not Hispanic or tatino   Not Hispanic or tatino   Not Hispanic or Indiano   Not Hispanic or Hi	Specialist Physician who referred you:		_Town:	Phone:	
Ethnicity   Hispantic or Latino   Not Hispanic or Latino   Declined to state   Language(s) spoken:   Preferred Pronouns   HisPithin   Shighter   Direcy/Them General Internation   Lebian, Cay, or Homosexual   Straight or Heterosexual   Diseasal   Declined   Other.   Sexual Omeration   Lebian, Cay, or Homosexual   Straight or Heterosexual   Diseasal   Declined   Other.   Sexual Omeration   Lebian, Cay, or Homosexual   Straight or Heterosexual   Diseasal   Declined   Other.   Sexual Omeration   Lebian, Cay, or Homosexual   Straight or Heterosexual   Diseasal   Diseasal   Declined   Other.   Sexual Omeration   Diseasal   Diseasal   Declined   Other.   Declined   Other.   Declined   Other.   Declined   Other   Declined   Other   Declined   Other.   Declined   Other   Declined   Other.   Declined   Other   Declined   Other   Declined   Declined   Other   Declined	Your Cardiologist (if applicable):		Town:	Phone:	
Preferred Pronounce:   replin   Shepher   They/Them   Secund Orientation   dentifies as Medic   dentifies as few field   Student   Declared   Declared   Other   Sexual Orientation   Declared   Decl	Race:  White  American Indian or Alaska Native	☐ Asian ☐ Black or African Ar	merican 🗖 Native Hawa	iian or Other Pacific Islander	
MEDICAL EMERGENCY INFORMATION Relationship:	Preferred Pronouns: ☐ He/Him ☐ She/Her ☐ They/They/The Gender Identity: ☐ Identifies as Male ☐ Identifies as	nem Female 🗖 Transgender Male 🖵	<b>1</b> Transgender Female □	☐ Gender Non-conforming ☐	
CANCELLATION & NO-SHOW POLICY  ()_ (patient initials) As a courtesy to our providers and other patients, if you need to cancel or reschedule your appointment, we ask that you notify us at least 48 hours in advance and 72 hours in advance for consender patients, if you need to cancel or reschedule your appointments that are canceled the same day as the appointment, not showing for an appointment, or when a patient arrives 15 minutes after their scheduled appointment time. A <i>Lote Cancellation</i> or considered class and real than 72 hours prior to a 60-minute cosmicit appointment. We reserve the right to otharge a non-refundable cancellation or no-show feed \$50-\$100 for a general dermatology appointment. If a scheduling fee is required when scheduling a cosmetic appointment, that fee is forfieted if a patient is considered a no-show or has given a late cancellation notice.  AUTHORIZATION TO BILL INSURANCE  I hereby authorize and request my insurance company to pay bermcare directly the amount due on my claim for services provided to my dependent or me. I also agree that should the amount be insufficient to cover the entire medical and/or surgical expense, I will be responsible for the payment for the difference and if the service provided is Patient Signature:  Print Name:  Print Name:    Print Name:   Date:	Employment Status:  Full-time  Part-time  R	etired 🗖 Student 💮 Occupation	on:		
CANCELLATION & NO-SHOW POLICY  ()_ (patient initials) As a courtesy to our providers and other patients, if you need to cancel or reschedule your appointment, we ask that you notify us at least 48 hours in advance and 72 hours in advance for consender patients, if you need to cancel or reschedule your appointments that are canceled the same day as the appointment, not showing for an appointment, or when a patient arrives 15 minutes after their scheduled appointment time. A <i>Lote Cancellation</i> or considered class and real than 72 hours prior to a 60-minute cosmicit appointment. We reserve the right to otharge a non-refundable cancellation or no-show feed \$50-\$100 for a general dermatology appointment. If a scheduling fee is required when scheduling a cosmetic appointment, that fee is forfieted if a patient is considered a no-show or has given a late cancellation notice.  AUTHORIZATION TO BILL INSURANCE  I hereby authorize and request my insurance company to pay bermcare directly the amount due on my claim for services provided to my dependent or me. I also agree that should the amount be insufficient to cover the entire medical and/or surgical expense, I will be responsible for the payment for the difference and if the service provided is Patient Signature:  Print Name:  Print Name:    Print Name:   Date:					
CANCELLATION & NO-SHOW POLICY  (i) (patient initials) As a courtesy to our providers and other patients, if you need to cancel or reschedule your appointment, we ask that you notify us at least 48 hours in advance and 72 hours in advance for counted appointments for 60 minutes or longer. Mo-Show appointments are considered appointment that are canceled the same day as the appointment of the own appointment, or the preferred contact phone number. We reserve the right to charge a non-retundable acceleration on considered as non-retundable acceleration on the considered as no-show or has given a late cancellation notice.  **AUTHORIZATION TO BILL INSURANCE**  I hereby authorize and request my insurance company to pay Dermcare directly the amount due on my claim for services provided to my dependent or me. I also agree that should the amount be insufficient to cover the entire medical and/or surgical expense, I will be responsible for the payment for the difference and if the service provided is Patient Signature: Print Name: Date:			Relationship:		
to bourst initials) As a courtest to our providers and other patients, if you need to cancel or reschedule your appointment, we ask that you notify us at least 48 hours in advance and 72 hours in advance for cosmetic appointments for 60 minutes or longer. No-Show appointments are considered appointment time. A clue Concellation is considered less than 72 hours prior to a 60 minute cosmetic appointment, or when a patient arrives 15 minutes after their scheduled appointment time. A clue Concellation is considered less than 72 hours prior to a 60 minute cosmetic appointment. We reserve the right to charge a non-refundable cancellation or no-show fee of \$50-\$100 for a general dermatology appointment. If a scheduling fee is required when scheduling a cosmetic appointment, that fee is forefield ff a patient is considered a no-show or has given a late cancellation notice.  **AUTHORIZATION TO BILL INSURANCE**  Ihereby authorize and request my insurance company to pay Dermare directly the amount due on my claim for services provided to my dependent or me. I also agree that should the amount be insufficient to cover the entire medical and/or surgical expense, I will be responsible for the payment for the difference and if the service provided is a survey and the amount be insufficient to cover the entire medical and/or surgical expense, I will be responsible for the payment for the difference and if the service provided is a survey and the service provided in the service provided is the service of the privacy practices at Dermacare available at <a href="https://www.apderm.com">www.apderm.com</a> and posted in the office.  **Print Name:    print Name:   patient trials   understand that if I email photos or protected health information to this office, Dermacare is only responsible for the content once received in this office and it will become part of your permanent electronic medical record. I also understand that when I town the particle with my own personal health information such as my visit summany, pre/port operative	Home Phone:		Cell Phone:		
HIPAA PRIVACY INFORMATION — Acknowledgement of Receipt of Notice of Privacy Practices Privacy notice of the privacy practices at Dermcare available at <a href="https://www.apderm.com">www.apderm.com</a> and posted in the office.	the same day as the appointment, not showing for an considered less than 72 hours prior to a 60-minute cogeneral dermatology appointment. If a scheduling fee given a late cancellation notice.  AU  I hereby authorize and request my insurance company	appointment, or when a patient smetic appointment. We reserve is required when scheduling a comment of the comm	t arrives 15 minutes afte the right to charge a no osmetic appointment, the OBILL INSUF	r their scheduled appointmen on-refundable cancellation or nat fee is forfeited if a patient RANCE or services provided to my dep	t time. A Late Cancellation is no-show fee of \$50-\$100 for a is considered a no-show or has pendent or me. I also agree that
HIPAA PRIVACY INFORMATION — Acknowledgement of Receipt of Notice of Privacy Practices Privacy notice of the privacy practices at Dermcare available at <a href="https://www.apderm.com">www.apderm.com</a> and posted in the office.	Patient Signature:		Print Name:		Date:
Privacy notice of the privacy practices at Dermcare available at <a href="www.apderm.com">www.apderm.com</a> and posted in the office.  I	Guardian Signature:		Print Name:		Date:
May we leave other medical information on/with?  Home Answering Machine:  Cell Phone Voicemail:  Automated Appointment/Reminder Calls	Privacy notice of the privacy  I(patient initials) understand that if I em in this office and it will become part of your perm information such as my visit summary, pre/port oper  We will leave appointment reminders on the prefer	practices at Dermcare avail photos or protected health in anent electronic medical recordative instructions, etc., it is my record to the contraction of the contract	railable at www.apenformation to this office, d. I also understand that responsibility to keep thin Authorization to dis	derm.com and posted in Dermcare is only responsible it when I leave the practice is information private and insacuss my appointments and He	for the content once received with my own personal health afe keeping.
Home Answering Machine:	May we leave other medical information on/with?				
Cell Phone Voicemail:	_	es 🗖 No	r		
Automated Appointment/Reminder Calls	-	es 🗖 No	Name:		
Print Name:	Automated Appointment/Reminder Calls	☐ No ☐ Opt out			
Print Name:	• •	·			-
Guardian Signature:Date:  Date:  I decline to give anyone permission to have access to my medical information  Print Name:  (Patient initials)(Guardian initials)	<u>-</u>	<del></del>			
☐ I decline to give anyone permission to have access to my medical information  Print Name:(Patient initials)(Guardian initials)					
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