dermcare™
PHYSICIANS & SURGEONS

GENERAL PATIENT INFORMATION

Patient Name:______________________________ Preferred Name: ______________________________

Date of Birth:______________ Marital Status: S M W D Sex Assigned at Birth: ❑ Male ❑Female Legal Sex: Same as sex assigned at birth ❑Yes ❑No

Address:______________________________ City:______________ State:________ Zip:________

Check Preferred Contact Method: ❑ Home Phone______________ ❑ Cell Phone: ______________ Consent to Text: ❑Yes ❑No

Email Address:______________________________ (Email address to be used to communicate health events, practice news, cosmetic specials and events only generated by the practice administrator. Email addresses are kept securely within our practice management system only.)

Primary Care Physician:______________________ Town:______________ Phone:______________

Specialist Physician who referred you:______________ Town:______________ Phone:______________

Your Cardiologist (if applicable):______________ Town:______________ Phone:______________

Race: ❑ White ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Declined to state Language(s) spoken: ______________________
Preferred Pronouns: ❑ He/Him ❑ She/Her ❑They/Them
Gender Identity: ❑ Identifies as Male ❑ Identifies as Female ❑ Transgender Male ❑ Transgender Female ❑ Gender Non-conforming ❑Declined ❑Other.
Sexual Orientation: ❑ Lesbian, Gay, or Homosexual ❑ Straight or Heterosexual ❑ Bisexual ❑ Declined ❑Other.

Employment Status: ❑ Full-time ❑ Part-time ❑ Retired ❑ Student Occupation: ______________________

MEDICAL EMERGENCY INFORMATION

Contact Name: ______________________ Relationship: ______________________

Home Phone: ______________________ Cell Phone: ______________________

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 cosmetic appointments for 60 minutes or longer. *No-Show* appointments are considered 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 *Late Cancellation* 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 forfeited if a patient is considered a no-show or has given a late cancellation notice. Three no-show appointments within a 12-month period will put you in jeopardy of scheduling with the clinician and possible dismissal from the practice.

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 considered a non-covered service; I will be responsible for payment of that service.

Patient Signature: ______________________ **Print Name:**______________ **Date:** ________

Guardian Signature: ______________________ **Print Name:**______________ **Date:** ________

HIPAA PRIVACY INFORMATION – Acknowledgement of Receipt of Notice of Privacy Practices

Privacy notice of the privacy practices at Dermcare available at www.apderm.com and posted in the office.

I_________**(patient initials)** understand that if I email photos or protected health information to this office, Dermcare 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 leave the practice with my own personal health information such as my visit summary, pre/port operative instructions, etc., it is my responsibility to keep this information private and in safe keeping.

We will leave appointment reminders on the preferred contact phone number that you provided at the time of the appointment.

May we leave other medical information on/with?

Home Answering Machine: ❑ Yes ❑ No

Cell Phone Voicemail: ❑ Yes ❑ No

Automated Appointment/Reminder Calls ❑ Yes ❑ No ❑ Opt out

Patient Signature:______________________ **Date**: ____________

Print Name: ______________________

Guardian Signature:______________________ **Date**: ____________

Print Name: ______________________

Relationship to Patient: ______________________

Authorization to discuss my appointments and Health information with:

Name: ______________________

Relationship:______________________

Name:______________________

Relationship: ______________________

Name:______________________

Relationship: ______________________

❑ I decline to give anyone permission to have access to my medical information

__________**(Patient initials)** __________**(Guardian initials)**

Form date: 03.2024