

Atlantic Shore Dermatology

PATIENT INFORMATION AND HISTORY FORM

Chart# _____

Last Name _____ First Name _____ MI. _____ SSN _____

Sex: Male or Female _____ Date of Birth ____ - ____ - ____ Marital Status: S W D M

Home Address _____ City/State _____ Zip Code _____

Mailing Address _____ City/State _____ Zip Code _____

IS ADDRESS: PERMANENT OR TEMPORARY? (circle one)

Home Phone _____ Work Phone _____

E-mail Address _____ Cell Phone _____

Patient's Employer (if student, name of school) _____

Employer's Address _____

SPOUSE OR GUARDIAN

(Without this information, we cannot file a claim and you will be responsible for the bill the day of service.)

Name _____ Date of Birth _____ SSN _____

Employer _____ Address _____ Phone # _____

EMERGENCY CONTACTS

Nearest relative not living with you _____ Phone _____

Nearest friend not living with you _____ Phone _____

Family Physician _____ Phone _____

Referring Physician _____ Address _____ Phone _____

I agree the above information is correct. _____
Print Name Signature Date

Disclosure of Protected Health Information

By law, medical information is confidential unless written authorization is given.

Therefore, I _____ authorize Atlantic Shore Dermatology to release medical information to the following persons:

I request that you DO NOT disclose medical information to anyone other than me. _____
Initials

I can be contacted at _____ Daytime Phone # _____

_____ Home Phone # _____

_____ Cell # _____

_____ Leave message and or results on Answering machine

This authorization remains in effect until I give written notification to discontinue.

Patient Signature: _____

Date: _____