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:** _____