Last Name_____ First Name_____ Middle Initial _____

Mailing Address_____ City_____ State_____ Zip_____

Home Phone (____)_____-_____ Cell (____)_____-_____ Work (____)_____-_____

DOB_____ /_____ /_____ Social Security Number_____-____-_____ Male_____ Female_____

Marital Status_____ Race (Circle One): White Hispanic African American Asian Other

E Mail _____

Primary Care Physician_____ Were you referred by s/he? Yes____ No_____

Preferred Pharmacy Name_____ Address_____

Insurance Information ☐ Self Pay

Primary Ins Co _____

Relation to policyholder _____

If the patient is **not** the policyholder, please fill out the following:

Policyholder's Name_____

Policyholder's DOB_____ SSN_____

Secondary Ins Co_____

Relation to policyholder _____

If the patient is **not** the policyholder, please fill out the following:

Policyholder's Name_____

Policyholder's DOB_____ SSN_____

Emergency Contact_____ Relationship_____ Phone(____)_____-_____

By signing below, I request payment of insurance/Medicare benefits to be made on my behalf to Northern California Dermatology Center, Inc. I am authorizing any necessary medical information to be released to my insurance/Medicare to pay a claim. I understand that I am responsible financially for any deductible, co-insurance, or non-covered services.

_____ _____

Patient/Parent/Guardian Signature Date

HIPAA Acknowledgement

By signing below, you are acknowledging that you have had an opportunity to review, if desired, this practice's *"Notice of Privacy Practices."*

Please mark which phone number(s) we can use to leave a message identifying this practice:

Home _____ Cell _____ Work _____

Please mark which phone number(s) we can use to leave laboratory results or other care issues:

Home _____ Cell _____ Work _____

To whom, if anyone, may we disclose laboratory/biopsy results or other care issues?

Name_____ Relationship_____ Phone(____)_____-_____

_____ _____

Patient/Parent/Guardian Signature Date