Westerville Dermatology ***235 W. Schrock Rd. Westerville, Oh 43081 ph.614-895-0400***

Patient Demographics

Marital status:

Legal Name: First_____ Last: _____ S / M / other

Date of Birth: _____ Home Address: _____

City: _____ State: _____ Zip: _____

☐ Home Phone: _____ ☐ Cell Phone _____ [x] CHECK BOX BESIDE PREFERRED CONTACT

Gender: M /F /T Language: English/Other _____ Email: _____

Primary Care Physician: _____ Primary Care Phone: _____

Referred by: ☐ Primary Care Physician ☐ Family member ☐ Other _____

Emergency Contact: _____ Emergency Phone:_____

Pharmacy: _____ Occupation: _____

Social Security #: _____ May we send you cosmetic specials via email ❒ Yes ❒ No

Insurance

Are you (the patient) the primary insurance carrier? Yes ❒ No ❒ (if no, answer questions below)

Policy Holder Name:_____ Relationship:_____ Date of Birth:_____

Release of Information

May we leave test results/other clinical information on an answering machine? Yes ❒ No ❒

Information regarding medical information and financial account with the following individuals listed, unless otherwise communicated to the practice:

NAME	RELATIONSHIP	PHONE NUMBER

CONSENT

MY SIGNATURE BELOW AUTHORIZES ALL THE FOLLOWING:

- I consent for the practice to bill my insurance carrier according to the most recent insurance information and insurance cards including, Medicare and Medicaid Advantage Plan Cards that I have provided. I understand that all balances are my responsibility, including those any items that may not be billed to my insurance (such as cosmetic procedures). This includes co-pays, co-insurance amounts, deductible amounts. If I am uninsured, I understand that I am responsible for all charges for the services provided.
- This practice may release information to my insurance company, primary care/referring physician, and any other covered entities in accordance with the HIPAA privacy act. I have: ❒ **Received** ❒ **Declined the Privacy Notice** and I understand my rights as a patient with regard to privacy of health care information.
- I am aware that if I am more than 15 minutes late to my appointment I may be rescheduled. I also understand the multiple no show appointments and/or late arrivals may result in my dismissal from the practice.
- My signature is valid indefinitely unless there is a change to these policies and/or I request to remove my authorization.

Signature_____ Date: _____