Eastern Dermatology
& Pathology

# Patient Information and Consent

## Patient Name

Last Name First Name Middle Nickname

## Patient Demographics

Birth Date Gender Marital Status

Email Address (We will never rent or sell your email address – we value your privacy.)

Race_____ Ethnicity _____

Mailing Address Apt. # City State Zip

Home Phone Mobile Phone Work Phone

Preferred Contact Method _____ Can we leave a detailed message? _____

## Emergency Contact Information

Contact Name Phone # Relationship to Patient

## Responsible Party's Information (if someone other than patient)

Legal Name of Responsible Party Date of Birth Address City State Zip

Pharmacy Name Phone Number Location

Referring Physician Primary Care Physician

I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the Eastern Dermatology Privacy Practice Notice. I authorize payment of medical benefits to Eastern Dermatology for services rendered. I authorize Eastern Dermatology to perform any services necessary for proper treatment. I understand that I am financially responsible for all charges including deductibles, co-insurance and non-covered medical procedures.

By signing this consent, I am acknowledging that I have received a copy of the Notice of Privacy Practice from Eastern Dermatology.

This authorization will remain valid until written novice is given by me revoking said authorization.

Patient or Authorized Person's Signature _____ Date _____