Western Maryland Dermatology

(Please **Print** Legibly & Fill In or correct all Fields)

Patient's Name _____
First Middle Last

Address _____
Street & Apt # City State Zip

Home Phone _____ **Cell Phone** _____ Other _____

Any restrictions for contacting you? □No □Yes Contact Restrictions _____

Email Address _____

Age _____ **Birthdate** _____ **SSN#** _____

Sex □ Male □ Female

Marital Status □ Single □ Married □ Other _____

Spouse's Name _____ **Spouse's DOB** _____

Race □ White □ Black or African American □ Asian □ American Indian or Alaska Native
□ Native Hawaiian or Other Pacific Islander □ Other

Ethnicity □ Hispanic or Latino □ Not Hispanic or Latino **Language** _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext _____ Is it ok to call you at work? □ Yes □ No

Emergency Contact Name _____ Relationship to Patient _____

Home Phone _____ Cell/Work Phone _____

Primary Care Physician _____ **Pharmacy** _____

Responsible Person If Other Than Patient
Name _____ Relationship to Patient _____
Address _____
Phone Number _____ Employer _____

How did you hear about Western Maryland Dermatology? □ Newspaper □ Internet □ Family/Friend □ Radio
□ Established Patient □ Other _____

PRIVACY PRACTICES ACKNOWLEGEMENT
Western Maryland Dermatology

Initial : _____ *I have reviewed and understand the Notice of Privacy Practices, which has been dictated by the Health Portability and Accountability Act of 1996 or HIPAA. I consent to the disclosure of my Protected Health Information (PHI) to the designated person(s) below.*

Name: _____ Relationship: _____

Name: _____ Relationship: _____

FINANCIAL POLICY

Initial : _____ *I have reviewed a copy of the FINANCIAL POLICY as instructed. By signing this document, I certify that I understand and agree to Western Maryland Dermatology's Financial Policy.*

CANCELLATION POLICY

Initial : _____ *I have reviewed a copy of the CANCELLATION POLICY as instructed. By signing this document, I certify that I understand and agree to Western Maryland Dermatology's Cancellation Policy.*

PROCEDURAL CONSENT

Initial : _____ *I have reviewed a copy of the PROCEDURAL CONSENT as instructed. By signing this document, I certify that I understand and agree to Western Maryland Dermatology's Procedural Consent.*

Signature _____ **Date** _____