PATIENT CONFIDENTIAL INFORMATION

RoxyAnn Dermatology

Jeri K. Mendelson, MD, FAAD

PATIENT LEGAL NAME: _____.
First Middle Last

DOB:_____May we leave a message when we call or text? Yes_____No_____.

Home Phone: _____ Work Phone: _____

Cell Phone: _____ May we call you at work? ___ Yes ___ No

Email:_____ Social Security Number: _____.

Sex: Male / Female Marital Status: (Circle One) Single / Married / Divorced / Widowed

Physical Address: _____
Street City State Zip

Mailing Address if Different than Physical: _____

WHO IS YOUR PRIMARY CARE DOCTOR:_____

Employment/Self employment information: Occupation/Position: _____

Employer Name: _____ Phone Number: (___)_____

Who may we speak with regarding your medical care/ Emergency contact:
Name: _____ Relationship: _____Phone #: (___)_____

Spouse / Partner / Legal Guardian: (Circle One)

Name: _____ Phone Number: (___)_____

Primary Insurance: The guarantor is the person whose NAME is on the insurance card (yes) (no)
Name of Insurance Company: _____
Name of guarantor: _____ Relationship to Patient: _____
Guarantor DOB: _____ Guarantor SSN: _____

Secondary Insurance: Guarantor is the person whose NAME is on the insurance card (yes) (no)
Name of Insurance Company: _____
Name of guarantor: _____ Relationship to Patient: _____
Guarantor DOB: _____ Guarantor SSN: _____

Turn: ➡

PATIENT AUTHORIZATION FOR PAYMENT/RELEASE OF MEDICAL INFORMATION:

I understand that responsibility for payment for services provided in this office for myself, or my dependent, is mine. RoxyAnn Dermatology, LLC is billing your insurance company as a courtesy. Any non-covered, out of network charges and/or patient out of pocket balances such as copays, co-insurance and deductibles will be the patient's responsibility. In the event of default in payment from your insurance company, the responsible party agrees to pay any, and all costs from the services rendered. I authorize RoxyAnn Dermatology, LLC the release of any information as may be required by an insurance company, referring physicians or an attorney for the purpose of medical treatment or follow up. Unless prior special arrangements are made, accounts are to be paid on the day services are provided.

Signature: _____ Date: _____

Acknowledgement of Receipt of the Notice of Privacy Practices:

A **NOTICE OF PRIVACY PRACTICES** is provided to all patients on their first visit. This notice of Privacy Practices identifies how medical information about you may be used or disclosed. It explains your rights to access your medical information, to request an accounting of disclosures of your medical information and to request additional restrictions on our uses and disclosures of that information. It explains your rights to complain if you believe your privacy rights have been violated and our responsibilities to maintain the privacy of your medical information, and letting you know if that privacy is breached.

The undersigned has reviewed a copy of the **NOTICE OF PRIVACY PRACTICES** and is the patient or the patient's personal representative.

Name of Patient or Personal Representative: _____

Signature: _____ Date: _____