PETERSON DERMATOLOGY

Patient Information

First/Middle/Last Name			
DOB	Marital Status Single Married Divorced Widowed		
Home Address			
Mailing Address (if different from above)			
Email Address			
Home Phone#	Work Phone #	Cell Phone #	
Primary Care Physician	Employer		
Emergency Contact	Relationship	Emergency Contact #	

Consent

Consent for treatment: I consent to examination, diagnosis, and general medical care and treatment (including but not limited to: physical exam, administration of medications, diagnostic tests, laboratory tests, and other minor procedures) to be performed by office personnel, including physicians, nurses, and assistants.
Consent to import medications: I consent to my provider electronically requesting my prescription history information for the purpose of providing direct health care services.

_____ _____
Signature Date

HIPAA Privacy Compliance

Receipt of Notice of Privacy Practices
I hereby acknowledge receipt of the Peterson Dermatology NOTICE OF PRIVACY PRACTICES. The PRIVACY PRACTICE provides detailed information about how the practice may use and disclose my confidential information.

Would you like a paper copy of our HIPPA Privacy Practices?

- Yes
- No

_____ _____
Signature Date