PETERSON DERMATOLOGY

Minor Patient Regisration and Consent Form

First/Middle/Last Name		DOB
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 #

Responsible Party

Person responsible for payment if patient under 18:	
First/Middle/ Last Name:	
Mailing Address:	
Preferred Phone #:	DOB
Employer:	Employer Phone #:

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