ROCHESTER DERMATOLOGY CLINIC
PATIENT HEALTH INFORMATION

Patient's Name: _____
First Name Initial Last Name

Date of Birth (DOB):_____ Sex: ◯M ◯F

Address:_____

City _____ State _____ Zip _____

Home Phone: _____ Work Phone:_____ Cell:_____

Email: _____

We are required to obtain the following. Please note: Primary Language is required. If you choose not to answer Race or Ethnicity, please check "Unreported/Refuse to Report."

Primary Language of Patient:_____

Race: ◯ Asian ◯ American Indian or Alaska Native ◯ African American
◯ Native Hawaiian ◯ Other Pacific Islander ◯ White ◯ Unreported/Refuse to Report

Ethnicity: ◯ Hispanic or Latino ◯ Non Hispanic or Latino ◯ Unreported/Refuse to Report

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Employer:_____ Occupation:_____

Marital Status:_____ Name of Spouse:_____

Primary & Secondary Health Insurance:_____

Subscriber Name on Insurance: _____ DOB:_____

Name of Parents (if a minor): _____

Address if Different from Patient: _____

Person Responsible for Payment: _____

Emergency Contact: _____ Phone: _____

Are you being referred to our office ◯ Yes ◯ No

Primary Care Physician: _____

Phone: _____ Fax:_____

Is it OK to leave a detailed phone message regarding your medical information ◯ Yes ◯ No

Approval for Release of Information to Individuals
Our Physicians and staff maintain the highest level of patient confidentiality. Please designate the individuals to whom we may release information regarding your treatment, finances or needs.

I authorize that medical information may be disclosed to the following individuals and your primary care:

Last Name / First Name	Contact Number	Relationship

X_____ _____/_____/_____
Signature (Patient, Parent, Guardian) **Date**

Informed Consent for Medical Procedures

I hereby consent to any and all treatments that may be considered advisable or necessary in the judgement of the physician and physician's assistant. Any procedure(s) done in this office can possibly cause risks such as: bleeding, painful irritation, recurrence, infection, scabbing, scarring and/or swelling. If your insurance does not cover the procedure(s), payment is your responsibility.

Financial Arrangements and Insurance

We are committed to providing you with the best possible care. If you have insurance, we are willing to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy. We emphasize, then, as health care providers; our relationship is with YOU, not your insurance company. It is necessary for you to be aware of your benefits.

You must also be aware of what laboratory your insurance covers. Lab tests are not included in the physicians' fee. The patient is responsible for all costs incurred by the lab which are not covered by their insurance. You will be billed separately by the lab for charges such as the appropriate copays or deductibles.

I authorize Rochester Dermatology Clinic to release any medical information necessary to process my insurance claim and I authorize payment of medical benefits to be made to the provider listed above for the services rendered.

If you have any questions about the above information, please do not hesitate to ask us. We are here to assist you.

I have read, understand and agree to the above financial policy.

X_____ _____/_____/_____

Signature (Patient, Parent, Guardian) **Date**

Notice of Privacy Practices

I have been offered and/or received a copy of Rochester Dermatology Clinic Notice of Privacy Practices. Additional copies are available at any time at our front desk or on our website. We will be happy to answer any questions or discuss any component of these rights and responsibilities.

X_____ _____/_____/_____

Signature (Patient, Parent, Guardian) **Date**