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 _____

Preferred Phone: _____Home or Cell (circle one)

Marital Status:_____ Name of Spouse:_____

Who is responsible for the bill:_____

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: _____

Ethnicity: ___Hispanic or Latino ___Non Hispanic or Latino ___Unreported/Refuse to Report

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Emergency Contact: _____ Phone: _____

Are you being referred to our office ____Yes ____ No

Referring 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

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. 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.

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/notice of privacy practices.

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**