GREATER WASHINGTON DERMATOLOGY / ADCS PATIENT INFORMATION SHEET

DEMOGRAPHIC INFORMATION

Name: _____ **Date of Birth:** _____ **Age:** _____ **Sex:** M F

Marital Status: S M W D SEP **Spouse Name:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

E-Mail: _____ **Employer:** _____

Home Phone: _____ **Cell Phone:** _____ (Circle preferred)

Please answer the questions below by government mandate:

Race: White American Indian Asian African American Pacific Islander Other

Ethnicity: Not Hispanic or Latino Hispanic or Latino Other Decline to Specify

Preferred Language: English Spanish Other: _____

Referring Physician: _____ **Phone:** _____

Primary Care Physician: _____ **Phone:** _____

Emergency Contact: _____ **Phone:** _____

Please provide your insurance card and photo-ID to the receptionist

Insurance: _____ **Policy/Member ID:** _____

Subscriber: _____ **Relation to Subscriber:** _____

You have the right to request restrictions on certain uses and disclosures of protected health information including those related to disclosures to family members, other relatives, close personal friends, and any other person identified by you.

May we leave a detailed voicemail? Circle One: YES NO

With whom may we share your medical information? _____

For Patient's 65 and older: Do you have a healthcare proxy in the event you are unable to make your own medical decisions? Circle One: YES NO

If yes, Designee Name: _____ phone

All prescriptions, including refills, will be sent to your pharmacy listed below electronically unless you notify us otherwise.

Pharmacy Name: _____

Pharmacy Address: _____ **Phone:** _____

Are you interested in prescriptions being sent to a specialty pharmacy (Rx mailed to your address, may be more affordable for some insurance plans) YES NO

Do you consent to having your prescription history imported via electronically thru your pharmacy for purposed of providing direct health care services?
Circle one: YES NO

We will bill your insurance company if we participate with that company. You are responsible for any and all charges that your insurance company does not cover. These include, deductibles, co-pays, and non-covered services, which are due at time of service. Parents or guardians are responsible for payments on child accounts. All tissue removed will be sent for pathologic preparation and examination. You may request a copy of your *Notice of Privacy Practices* at any time. By signing below I certify that I understand the above information and that the information I have given is correct to the best of my knowledge.

Signature: _____ **Date:** _____

Signature of parent or guardian is required if patient is under 18.