DERMATOLOGY OF CENTRAL OHIO

161 Clint Drive, Suite 100
Pickerington, OH 43147
Phone: (614)-866-8603
Fax: (614)-866-8699

Patient Demographics

Last Name: _____ First Name: _____ MI____

D.O.B _____/____/_____ Gender: M/F/T Email: _____

Language: English/ Other: _____ Race: _____ Ethnicity:_____

Home Address: _____

☐ Home Phone: _____ ☐ Cell Phone _____ [x] CHECK BOX BESIDE PREFERRED CONTACT METHOD

Primary Care Physician: _____ Primary Care Phone: _____

Pharmacy: _____ Occupation: _____

May we send you information via email regarding cosmetic specials ❒ Yes ❒ No

Insurance

Are you (the patient) the primary insurance carrier? Yes ❒ No ❒ (if no, answer questions below)

Policy Holder Name:_____ Relationship:_____ Date of Birth:_____

Release of Information

May we leave test results/other clinical information on an answering machine? Yes ❒ No ❒

Information regarding medical information and financial account with the following individuals listed, unless otherwise communicated to the practice. You also authorize the below to be an emergency contact:

NAME	RELATIONSHIP	PHONE NUMBER

CONSENT

MY SIGNATURE BELOW AUTHORIZES ALL THE FOLLOWING:

- I consent for the practice to bill my insurance carrier according to the most recent insurance information and insurance cards including, Medicare and Medicaid Advantage Plan Cards that I have provided. I understand that all balances are my responsibility, including those any items that may not be billed to my insurance (such as cosmetic procedures). This includes co-pays, co-insurance amounts, deductible amounts. If I am uninsured, I understand that I am responsible for all charges for the services provided.
- This practice may release information to my insurance company, primary care/referring physician, and any other covered entities in accordance with the HIPAA privacy act. **I have: ❒ Received ❒ Declined the Privacy Notice and I understand my rights as a patient with regard to privacy of health care information.**
- I am aware that if I am more than 15 minutes late to my appointment I may be rescheduled. I also understand the multiple no show appointments and/or late arrivals may result in my dismissal from the practice.
- My signature is valid indefinitely unless there is a change to these policies and/or I request to remove my authorization.

Signature_____ Date: _____