DERMATOLOGY HEALTH SPECIALISTS

1693 SW Chandler Ave, Suite 250 Bend, OR 97702
57067 Beaver Drive, Sunriver OR 97707
Phone: 541-382-8819
Fax: 541-797-7971
www.derm-health.com

General Information

Please fill in all missing information, *verify and/or correct any printed information. Please print legibly.*

Patient's Name: _____ **Age:** _____ **Birthdate:** _____
Last First Middle

Address: _____ **E-mail:** _____
Street and Apt Number City State Zip

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____ **Ext.** _____

Primary contact: *Home☐ Work☐ Cell☐* ***Auth. to E-mail:*** Yes☐ No☐ ***Auth. to Leave Voicemail:*** Yes☐ No☐ ***Auth. to Text:*** Yes☐ No☐

Sex: _____ **Marital Status:** _____ **Race:** _____ **Ethnicity:** _____ **Language:** _____

Referring Physician: _____ **Phone number:** _____

Address: _____
Street and Suite Number City State Zip

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

Address: _____
Street and Suite Number City State Zip

Emergency Contact: _____ **Relationship to Patient:** _____

Home Phone: _____ **Work Phone:** _____ **Other Phone:** _____

Parent or Responsible Party: *(If different from patient)* **Name:** _____ **Phone:** _____

Address: _____ **Relationship to patient:** _____
Street and Apt Number City State Zip

Primary Insurance Company: _____ **Policy #:** _____ **Group #:** _____

Name of Subscriber: _____ **Subscriber Date of Birth:** _____ **Relationship:** _____

Secondary Insurance Company: _____ **Policy #:** _____ **Group #:** _____

Name of Subscriber: _____ **Subscriber Date of Birth:** _____ **Relationship:** _____

Please Read Carefully. I hereby authorize and assign my insurance benefits to be paid directly to Dermatology Health Specialists, P.C. I authorize release of information to facilitate treatment, payment or heath care operations. I give Dermatology Health Specialists, P.C. permission to treat me and take photographs. Co-payments and/or outstanding balances are due at the time of your appointment. I agree that I will be financially responsible for any treatment I receive, in the event that my insurance company denies payment. I will be responsible for a $50 fee in the event that: (1) my check is returned for insufficient funds, or: (2) my account is turned over to a collection agency, or; (3) I fail to show up for my appointment and have not notified your office **at least two business days** in advance of the appointment. I understand that any illicit, sexually suggestive or otherwise inappropriate behavior by me may result in immediate termination of service and dismissal. My signature below signifies my understanding and agreement to comply with these policies.

I have read and understand the Notice of Privacy Rights and Practices and Dermatology Health Specialists Policies.

Signature of Patient (or responsible party) _____ Date _____

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Authorization to share patient medical and financial information with others (optional):

I authorize the following person(s) to have access to my medical and financial information. This authorization may be revoked in writing at any time.

Family Members

Name:_____ Phone number: _____

Name:_____ Phone number: _____

Name:_____ Phone number: _____

Others

Name:_____ Phone number: _____

Name:_____ Phone number: _____

Name:_____ Phone number: _____

Name:_____ Phone number: _____

Signature of Patient (or responsible party)_____ Date _____

Patient's Printed Name _____Date of Birth _____