Patient Information (PLEASE PRINT): **Today's Date:**

Last Name:	First Name:	Middle Initial:	Drivers License No.:
Birth Date: Age:	Marital Status: Single Married Widowed Divorced		Sex: Male Female
Street Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	Social Security No.:
Employer:		Occupation or Student Status: Part-time Full-time	
E-mail Address: ____ (E-mail correspondence will be used for purposes within our office only. We do not provide patient information to third parties. If we have your e-mail address, we will use it to send you appointment reminders in addition to a call.)		How you were referred to our office? Please check all that apply: ☐ Friend (name): ________________________ ☐ Physician (name): ________________________ ☐ E-mail advertisement or promotion ☐ Internet	

Emergency Contact:

Name:	Home Phone:	Work Phone:	Cell Phone:	Relationship to Patient:

Financially Responsible Party (if other than the patient):

Last Name:	First Name:	Middle Initial:	Drivers License No.:
Birth Date: Age:	Marital Status: Single Married Widowed Divorced		Sex: Male Female
Street Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	Social Security No.:
Employer:		Occupation or Student Status: Part-time Full-time	
E-mail Address: ____ (E-mail correspondence will be used for purposes within our office only. We do not provide patient information to third parties.)			

AUTHORIZATION FOR TREATMENT, PAYMENT, AND INFORMATION RELEASE

I consent to treatment necessary for the care of the patient indicated on this form. Authorization is hereby granted to Tarrant Dermatology Consultants, PA to release information such as medical records that may be necessary to process and complete my claim. I hereby authorize payment of medical benefits to be paid directly to Tarrant Dermatology Consultants, PA for services rendered. I accept the risk that information transmitted through facsimile (fax) communication devices and over the internet may be intercepted or inadvertently transmitted to people not authorized to receive the information. I hereby authorize the transmission of my medical records, or any part thereof, through facsimile (fax) communication devices and over the internet. Additionally, I understand that some procedures / services performed by the healthcare provider(s) may not be covered by my insurance plan. If services are not covered, I understand and agree to be financially responsible for payment in full for such services.

____ ____

Patient (if over 18 years old) or Parent/Legal Guardian Signature **Date**