PATIENT INFORMATION FORM

NW MD
NORTHWESTERN MICHIGAN DERMATOLOGY, PC

Name: (First, M.I., Last) _____

Address: _____

City:_____ ST _____ ZIP _____

Email: _____

Social Security No: _____

Date of Birth:_____

Driver's License No.: _____State: _____

Primary Phone:_____ ☐ Home ☐ Cell

Secondary Phone: _____ ☐ Home ☐ Cell

Preferred Contact Method: ☐ Phone ☐ Email ☐ Mail

Gender*: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Ethnicity*: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
☐ Prefer not to answer

**Required by Centers for Medicare & Medicaid for all patients*

In case of emergency, who should be notified?

Name:

_____

Relationship:_____

Phone:_____

Primary Care Physician_____

_____

INSURANCE INFORMATION

(Please present current insurance cards at time of check in)

Who is responsible for this account:?_____

Billing Address:_____

Primary Insurance: _____

Subscriber's Name: _____

Subscriber's Date of Birth_____

Relationship to Patient:_____

Secondary Insurance:_____

Subscriber's Name: _____

Subscriber's Date of Birth:_____

Relationship to Patient: _____

AUTHORIZATION TO RELEASE INFORMATION

_____ (*Please initial agreement*) I authorize information about my health care, including appointments, test results, or other messages to be left on my voicemail, in the event that I am not available.

_____ Yes, send message via text (standard rates may apply)

_____ (*Please initial agreement*) I authorize **Northwestern Michigan Dermatology, PC** to discuss information relevant to my care with:

☐ Parent ☐ Spouse ☐ Child/Children ○ Friend/Other ○ I do not authorize release to anyone

Please list names: _____

A copy of Northwestern Michigan Dermatology, PC's updated **Notice of Privacy Practices** is available for inspection at the reception desk at all times and on its web site. Additional copies of the notice can be obtained at no charge, upon request. By my signature below, I certify that I have read and understand the information disclosed in the notice. I also understand that changes to this notice can be made at any time, and that it is the patient's responsibility to remain current on those changes.

OFFICE POLICIES

A copy of Northwestern Michigan Dermatology, PC's updated **Office Policies** will be available for inspection at the reception desk at all times. Additional copies of the notice can be obtained at no charge, upon request. By my signature below, I certify that I have read and understand the information disclosed in the Office Policy notice. I also understand that changes to this notice can be made at any time, and that it is the patient's responsibility to remain current on those changes.

My signature below authorizes Northwestern Michigan Dermatology, PC to release my medical information to process my insurance claims. I also authorize payment of medical benefits to Northwestern Michigan Dermatology, PC. I understand I am financially responsible for any amount not covered by my insurance contract.

SIGNATURE: _____ **TODAY'S DATE:** _____
(Patient or Parent/Guardian if patient is a minor)

Rev 4-2022