

Patient's Legal Name:

_____ Suffix: _____
First Middle Last

Sex: M F Date of Birth: ____/____/____ Social Security # _____

Referring Doctor: _____ Primary Doctor: _____

Patient's Address: _____ Apt.#: _____
Street # Street Name City State Zip

Home phone: (____) _____ Work: (____) _____ Cell: (____) _____

Preferred phone for contact (if other than home): ____ Work ____ Cell (please remind our staff of contact number)

Email address: _____

Patient's Employer: _____ Job Title: _____

Parent/legal guardian name (if applicable): _____

Please list with whom we may discuss your medical information and/or notify in case of emergency:

Name: _____ Relationship _____ Phone: (____) _____

Name: _____ Relationship _____ Phone: (____) _____

Consent/Authorization to Treat:

I authorize Advanced Dermatology of Northern Indiana, P.C., it's care providers, and staff working under the name of DermacenterMD, to leave messages on my voicemail or answering machine to confirm future appointments. I also authorize messages regarding personal medical information (diagnosis, treatment, procedures, results from procedures/tests) to be left on the above listed voicemail, answering machine, email or Labcalls for notification.

I understand that I (or named patient) require treatment in this facility because of my (their) condition. I permit the physician or his employees, students in training, and all other persons caring for me (named patient) to provide treatment in ways they judge are beneficial to me (named patient). I understand that this care may include tests, nursing care, and examinations, medical and surgical treatment.

I authorize Advanced Dermatology of N. Indiana, P.C. to fax records to any physician or pharmacy for the purpose of coordinating and/or managing healthcare.

If patient is a minor: I (parent/guardian) authorize my provider to treat my underage child/dependent, and in the event of an emergency if this child/dependent is not accompanied by a parent/guardian, my provider may provide emergency treatment.

My health care provider may determine it is necessary to perform diagnostic test, medical, and/or surgical procedures judged by him/her as necessary for my (named patient) treatment and advise of risks and consequences of such procedures. I acknowledge that no guarantees have been made to me by my physician as to the result of any treatments, examinations, and/or operative procedures performed in the physician's office.

I acknowledge I have received a written copy of Advanced Dermatology of Northern Indiana, P.C.'s Notice of Privacy Practices. I acknowledge and will comply with the written copy of Advanced Dermatology of Northern Indiana, P.C.'s financial policy as posted in the waiting room. I acknowledge the practice of Advanced Dermatology of Northern Indiana, P.C. does not participate in Managed Health Services (Medicaid) nor does the practice participate in Tricare.

Signature: _____ **Date:** _____

Circle: Patient / Legal Guardian / POA

Patients under 18 must have their parent/legal guardian sign. Thank you.