For compliance with the government and to achieve "meaningful use" with our EHR
We need the following information.

Ethnicity: Patient declines_____

Check if **NOT** Hispanic or Latino_____
Check **if** Hispanic or Latino_____ (specify below)

_____Spaniard*
_____Mexican*
_____Central American*
_____South American*
_____Latin American
_____Puerto Rican
_____Cuban
_____Dominican

Race: (Select up to 3):

_____ Patient Declines
_____ Unknown to pt
_____ American Indian or Alaskan Native
_____Asian
_____Black or African American
_____Native Hawaiian or Pacific Islander
_____White
_____Other

Primary Language: _____

Contact Preference: **PLEASE CHOOSE 1 ONLY**

_____Primary Address
_____Home Phone
_____Mobile Phone/ PROVIDE # _____
_____Work Phone
_____Email/PROVIDE EMAIL_____

Request for Family Member to have access to Protected Health Information

Patient Name: _____
Date of Birth: _____/_____/_____
I, _____
authorize Pinnacle Dermatology to disclose my Protected Health Information (PHI) including billing information, to the following family members:

Name	Relationship
1. _____	_____
2. _____	_____
3. _____	_____

I understand I may revoke this authorization by sending a written request for revocation to Pinnacle Dermatology. I understand that when Pinnacle Dermatology discloses this information pursuant to this authorization; the information may no longer be protected by federal or state privacy rules and may be subject to redisclosure by the recipient of the information.
I understand and agree to the terms of this authorization:

_____ _____
Patient Signature Date

I authorize the release of medical information to my primary/referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize the payment of medical benefits to the physician.

Patient or Responsible Party Signature _____ Date _____

Name: _____ Birthdate:____/____/____ Sex _____ M _____ F

Marital Status: _____ Occupation:_____

Address:_____ Home # _____

City:_____ State:_____ Zip Code:_____ Cell # _____

Email: _____ Work # _____

Emergency Contact:_____ Phone#_____

Primary Physician first and last name:_____ Phone #_____

Who referred you to this office?_____

Medication Allergies_____

Other Allergies_____

Current Medications (including herbs, supplements, over-the-counter medications):_____

_____

Medical History: Please circle or write in current and past medical problems:

Anxiety	Depression	Hepatitis	Kidney/Urine Problems	Stomach disorders/ulcers
Arthritis	Diabetes	High Blood Pressure	Organ Transplant	Stroke
Asthma	GERD	High Cholesterol	Pacemaker	Tuberculosis
COPD/emphysema	Glaucoma	Hypo /Hyperthyroidism	Seasonal allergies	Former smoker
Defibrillator (AICD)	Headaches/Migraines	Irregular Heart rate	Seizures	Current smoker

Skin Cancer:_____ Other Cancer:_____

Other:_____

Do you have artificial joints or heart valves? Yes No Are you pregnant or breastfeeding? Yes No

Do you take antibiotics before teeth cleanings? Yes No Are you planning or trying to become pregnant? Yes No

INSURANCE INFORMATION (Please present insurance card at time of check in)

PRIMARY

Insurance Name _____

Name of Insured _____ Relationship to patient _____

Card Holders Date of Birth _____ Telephone Number_____

Card Holders Address if different from patients address _____

SECONDARY

Insurance Name _____

Name of Insured _____Relationship to patient _____

Card Holders Date of Birth _____

Card Holders address if different from patients address: _____

Responsible party name, billing address and phone number if different from patients address:

_____

_____