Hacker Dermatology
226 Palm Court, Delray Beach, FL 33444
Email: frontdesk@dermasurgerygroup.com
Tel: (561) 276-3111 Fax: (561) 926-9525

Name_____ SSN _____
Last First MI

Mailing Address _____
City State Zip

Alternate Mailing (if different from above)

_____
City State Zip

Date of Birth ____/____/____ Age ____ Sex: M / F Marital Status _____

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell: (_____)_____

Email Address: _____

Employer_____ Occupation_____

Spouse Name_____ Spouse Date of Birth ____/____/____

PARENT OR RESPONSIBLE PARTY (If Different from Patient)

Name _____ SSN_____
Last First MI

Date of Birth ____/____/____ Sex: M/F Home Phone: (_____)_____

Mailing Address _____
City State Zip

INSURANCE INFORMATION (Please Present Insurance Card at Time of Check-In)
Primary Insurance Name_____ Secondary Insurance Name_____
Name of Policy Holder_____ Date of Birth ____/____/____ Relationship: _____

PHARMACY INFORMATION

Name: _____ Address: _____ Phone: (_____)_____

EMERGENCY CONTACT

Contact Name _____ Relationship: _____ Phone: (_____)_____

Referred by: □ Doctor □ Patient □ Google □ Website □ News □ Top Doctor Website □ Other _____

I hereby request the professional services of Hacker Dermatology and agree to financial responsibility as indicated in the paragraph below: I understand that this office will only file insurance claims to plans in which they participate. If I am covered by a plan that they do not participate in, payment will be expected of me at the time of service. I authorize the release of medical information necessary to process claims, and also authorize payment of medical benefits to the physician. If my insurance does not pay, I will be financially responsible for payment in full. Any account with an unpaid balance will be charged interest in the amount of 2.0% per month until such time the account has been paid in full, including any attorney's fees and any other collection costs associated with the collection of unpaid balance.

Signature of Patient or Legal Guardian_____ Date _____/_____/_____

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Name _____ Date of Birth ____/____/____
Last First MI

Primary Care Physician_____

Do you smoke? □Yes □ No If yes, daily amount _____

Allergies
Do you have any medicine (Rx) allergies? □Yes □No

Type(s) of reaction: □Rash □Hives □Swelling □Anaphylaxis

Any other non -Rx allergies? □ Yes □No

If yes, please describe _____

Please list all allergies below	Reaction

List all prescription medications (Or attach a legible personal list):

1 _____ 11 _____
2 _____ 12 _____
3 _____ 13 _____
4 _____ 14 _____
5 _____ 15 _____
6 _____ 16 _____
7 _____ 17 _____
8 _____ 18 _____
9 _____ 19 _____
10 _____ 20 _____

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WRITTEN ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

You have the right to review our Notice of Privacy Practices before signing this Consent. The terms of our Notice may be subject to change. If we change our Notice, you may obtain a revised copy by contacting our office.

My signature below acknowledges that I have received a copy of Advanced Dermatologic Care and Center's Notice of Privacy Practices.

_____ _____

Signature of Patient or Legal Guardian Date

Out of respect for your privacy and in accordance with HIPAA, we need the following permissions to communicate with you:

- May we call you at home? _____
- May we call your cell? _____
- May we call your place of employment? _____
- May our doctors send email newsletter to your email address? _____
- May we discuss your medical condition with a member of your household? _____
    - If yes, whom_____ Relationship_____