Northwest Dermatology, S.C.
2500 West Higgins Road, Suite 1040, Hoffman Estates, Illinois 60169
Phone: 847-884-8096 Fax: 847-884-8125

Patient Name: ____ **Gender: M F** **Date:** ____________
Last First MIddle

Mailing Address: ____ **Apt. #:** ________

City: ____ **State:** ____________ **Zip:** ________

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

Email Address: ____ **Marital Status: S M W D**

Social Security Number: ______________________________ **D.O.B:** ____________________

Emergency Contact Name: ______________________________ Relation to Patient: ____________________

Home Phone: ____________________ Work Phone: ____________________ Cell Phone: ____________

Patient Employer: ____

Pharmacy Name: ______________________________ **Pharmacy Number:** ______________________________

Other family members that are currently patients: ____

Primary Insurance: ____

Insurance Address: ____

Insured Name: ____________________ Relation to Patient: ____________________ D.O.B: ____________

Subscriber ID: ____________________ Group Number: ____________________ SSN: ____________________

Secondary Insurance: ____

Insurance Address: ____

Insured Name: ____________________ Relation to Patient: ____________________ D.O.B: ____________

Subscriber ID: ____________________ Group Number: ____________________ SSN: ____________________

Insured Party's Employer Name: ______________________________ Work Phone: ____________________

Employer's Address: ____

Insurance Authorization and Assignment

I herby authorize Northwest Dermatology to furnish information to my insurance carriers concerning my diagnosis and treatments, and I assign to Northwest Dermatology all payments due for services rendered to myself or my dependents if I do not make payments in full for such services. In addition, I agree to pay applicable copayments and deductibles at the time of service.

If you have insurance through a company we have contracted with, we will require a copy of your insurance card and a picture id. If your insurance carrier requires a referral from your primary care physician, this must be present at the time of service. Failure to provide all necessary information may require you to pay in full on the date of the visit. It is your responsibility to keep track of the referral expiration dates and the number of visits given by your physician

____

(Date) (Print Signature Name) (Signature of Patient or Guardian)

Northwest Dermatology, S.C.
2500 West Higgins Road, Suite 1040, Hoffman Estates, Illinois 60169
Phone: 847-884-8096 Fax: 847-884-8125

Communication Policy and Waiver

May we call you at home?	Y N
May we call you at work?	Y N
May we call you via cell phone?	Y N
May we leave medical information on your answering machine?	Y N
May we leave appointment confirmation on your answering machine?	Y N
May we email medical information to you?	Y N
May we email appointment confirmation to you?	Y N
May we speak with another member of your household regarding medical information?	Y N

Name: ______________________________________ Relationship: ______________________________

I understand that the information provided on this communication waiver will remain in effect until revoked by me. I understand that I may revoke this consent at any time by written notice to Northwest Dermatology, S.C. I understand that I will not be able to revoke this consent in cases where the physician has already relied on its' use to disclose my health information.

____

(Date) (Print Signature Name) (Signature of Patient or Guardian)

Medical Services/Information Release

I authorize the release of medical information to my primary care or referring physician and to consultants, if needed.

____

(Date) (Print Signature Name) (Signature of Patient or Guardian)

Acknowledgement of Receipt of HIPPA Privacy Policies

Under the Federal HIPPA laws we are mandated to provide our patients with a copy of our Patient Privacy Policies. The notice provides detailed information about how Northwest Dermatology, S.C. may use and disclose my confidential information. I understand that Northwest Dermatology, S.C. has the right to change his or her privacy practices that are described in the notice and a revised notice will be provided to me upon request. Your signature is your acknowledgement that you have either received a copy today, have been offered a copy today or have downloaded it from our website at www.nwdermatology.com.

____

(Date) (Print Signature Name) (Signature of Patient or Guardian)