J. Matthew Knight, M.D.
801 N. Orange Avenue, Suite 520 Orlando, FL 32801
Phone: (407) 992-0660 | Fax: (407) 992-7702

1035 Primera Blvd, Suite 1041 Lake Mary, FL 32746
Phone: (407) 992-0660 | Fax: (407) 992-7226

Patient Registration Form

Name_____ Date of Birth _____/_____/_____
Last First MI

SSN _____ Email _____

Sex: □ Male □ Female Preferred Language: _____ Marital Status: _____

Home Address_____
(No P.O. boxes please) City State Zip Code
Mailing Address_____
City State Zip Code

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

Employer_____ Occupation_____

PARENT OR RESPONSIBLE PARTY **(If Different From Patient)**
Name_____ Date of Birth _____/_____/_____
Last First MI

SSN _____ Phone (_____) _____ Relationship _____

EMERGENCY CONTACT
Name _____ Phone (_____) _____
Last First MI

Please indicate how we may contact you regarding appointments, follow up, biopsy results, lab results, etc.?

May we call you at: □Home Number □Cell Number
May we leave a message at: □Home Number □Cell Number

May we discuss your health information with members of your household? □Yes □No

If yes, whom_____

I hereby request the professional services of J. Matthew Knight, M.D. P.A., and agree to financial responsibility as indicated in the paragraph below:
I understand that Knight Dermatology Institute 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.

_____ _____
Signature of patient or patient representative Date

_____ _____
Printed name of patient or patient representative Relationship to Patient

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J. MATTHEW KNIGHT, MD, PA
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
EFFECTIVE DATE: 08/26/2013

I have received a copy of the Notice of Privacy Practices (the "Notice") of J. Matthew Knight, MD, PA (the "company"). The Notice describes how my protected health information may be used or disclosed. I understand that I should read it carefully. In addition, I am aware that the Notice may change at any time. I may obtain a revised copy of the Notice by calling the Company or the Company's Privacy Officer at 407-992-0660, on the Company's website at www.knightdermatology.com, or by requesting one at the Company's offices.

_____ _____
Signature of patient or patient representative Date

_____ _____
Printed name of patient or patient representative Relationship to Patient