HONET DERMATOLOGY | COSMETIC
delivering the highest quality in dermatologic care

Welcome to Honet Dermatology and Honet Cosmetic

New Patient Registration Form (PLEASE PRINT) Date ____________________

How did you learn about our practice? ❑ Physician____________________ ❑ Relative ❑ Friend ❑ Website
❑ Internet ❑ Newspaper/Magazine ❑ Former Patient ❑ Business ❑ Social Media ❑ Other____________________

Patient's Full Name ____________________
Home Address ____________________
City ____________________ **State** __________ **Zip** __________
Home Phone __________ **Mobile Phone**__________ **Work Phone**__________
Emergency Contact ____________________ Emergency Contact Phone __________
Patient's Email Address ____________________
Patient's Date of Birth__________**Social Security Number**__________ Sex ❑ M ❑ F
Marital Status ❑ Single ❑ Married ❑ Widowed ❑ Divorced
Patient's Employer ____________________
If not employed, is patient... ❑ Retired ❑ Student ❑ Homemaker ❑ Unemployed ❑ Other __________
Patient Employer Address ____________________
City __________ State _____ Zip _____ **Employer Phone** __________

Patient's Primary Care Physician____________________Office Phone__________

Specialty Physician ____________________Office Phone__________

Specialty Physician ____________________Office Phone__________

Responsible Party Information
Who is financially responsible for the account? (Note: The responsible party can never be a child.)
Is the Responsible Party the same as the patient information? ❑ Yes ❑ No (if no, please fill in the information below)

Name ____________________
Address ____________________ **City** __________ **State** _____ Zip _____
Phone Number ____________________ Email Address ____________________

If patient is a MINOR, fill in responsible parent or guardian:
Guardian Name ____________________ **Relationship**__________
Guardian Address ____________________ City__________ State____ Zip _____
Guardian Phone Number __________ **Guardian Email Address** __________

I acknowledge the above information is correct and I accept financial responsibility for any services offered for myself or my dependent.
Signature of Patient or Legal Representative:

____________________ **Date** ____________________

Legal Representative's Relationship to the Patient: ____________________

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In Case of Emergency Contact(s) (Please list at least one additional contact)

1) Name ____ Relationship ________________
Phone of Emergency Contact_____________________________

2) Name ____ Relationship ________________
Phone of Emergency Contact_____________________________

3) Name ____ Relationship ________________
Phone of Emergency Contact_____________________________

Authorization to Release Health Information

Authorized Name and Relationship to Patient:

Name ____

Home Phone__________________Work Phone__________________Cell Phone__________________

Address____

City____ State____________ Zip Code______________

Date of Service: from ___________________to ___________________.

Release of Medical Information for: ❑All Records ❑Office Notes ❑Medications ❑Laboratory/Pathology Results

This Authorization will: ❑not expire until I give written notice of revocation.

❑will expire one (1) year from today's date as signed below.

I understand that:

- Once *Honet Dermatology/Honet Cosmetic* discloses my health information by my request and consent, it cannot guarantee that the recipient will not disclose my health information to a third party. The third party may not be required to abide by this authorization or the applicable federal and state laws governing the use and disclosure of my health information.
- I may request in writing at any time to inspect and/or obtain a copy of my health information maintained at *Honet Dermatology/Honet Cosmetic* as provided in the Federal Privacy Rule 45 CFR (164.524).
- My records are protected and cannot be disclosed without my written permission.
- I attest that to the best of my knowledge, the information contained herein is accurate and current.
- This Authorization will remain in effect as above, or I may provide a written notice of revocation to the *Honet Dermatology/Honet Cosmetic* at any time.

Signature of Patient or Legal Representative:

____ **Date:** ____________________________

Legal Representative's Relationship to the Patient: _______________________________________