GREATER NEBRASKA Dermatology

REGISTRATION INFORMATION

(Please Print)

Date _____

Patient _____

First Name Initial Last Name

Gender Male___ Female___

Date of Birth_____

SSN_____

E-Mail_____

Marital Status (Mark One) Single___ Married___ Widowed___ Separated___ Divorced___

Race

White___ Black___ Asian___ American Indian___ Native Hawaiian___ Unknown ___

Ethnicity

Hispanic___ Non-Hispanic___ Unknown___

Pharmacy_____ **Patient Language**_____

How Did You Hear About Us_____

Primary Care Physician_____

Referring Physician_____ **Patient Employed By**_____

Home Address _____ **Phone Numbers – Home**_____

_____ **Work**_____

_____ **Cell**_____

Is It Ok To Contact You At (Check All That Apply) Home___ Work___ Cell___ E-Mail___

It Is Ok To Speak With The Following People Regarding The Patient's Health Information_____

_____

_____

Name of Insurance Company_____

Policy #_____ **Policy Holder Name**_____ **DOB**_____

Group #_____**Group Name**_____ **SSN#**_____

Name of Secondary Insurance Company_____

Policy #_____ **Policy Holder Name**_____ **DOB**_____

Group #_____**Group Name**_____ **SSN#**_____

Responsible Party Name_____

Is your condition related to employment? Yes___ No___

Is your condition related to an auto accident? Yes___ No___

Is your condition related to other accident? Yes___ No___

Please Describe Injury_____

Emergency Contact_____ **Phone #**_____

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RELEASE OF INFORMATION

I hereby authorize Greater Nebraska Dermatology Clinic PC and its staff, to release to the above company(ies) or its representatives, to myself, to my primary care or referring physician(s), and to consulting physicians any information used for treatment or payment.

ASSIGNMENT OF BENEFITS AUTHORIZATION

I authorize payment of benefits directly to Greater Nebraska Dermatology Clinic PC. I understand that I am financially responsible for all charges not covered by my authorization.

HIPAA PRIVACY NOTICE

The signature below acknowledges that a copy of Greater Nebraska Dermatology Clinic PC's Notice of Privacy Practices is available upon request.

CONSENT TO MEDICAL TREATMENT

I, knowing that I have (or _____ has) a condition requiring diagnosis and medical treatment, do hereby voluntarily consent to such diagnostic examination procedures and to such medical treatment by Dr Daniel Mosel, his assistants or his designees as necessary in his judgment.

_____ _____

Signature of Patient or Person Legally Authorized to Consent for Patient Date