OUTER BANKS DERMATOLOGY

PATIENT INFORMATION DATE ______________

LAST NAME ______________ FIRST NAME ______________

ADDRESS ______________ CITY ______ ST ______ ZIP ______

SS# ______________ MARITAL STATUS ______ DOB ______________

SEX MALE ______ FEMALE ______ EMAIL ______________

TELEPHONE

HOME ______________ CELL ______________ WORK ______________

REFERRING PHYSICIAN ______________ PHARMACY ______________

PRIMARY PHYSICIAN ______________

INSURANCE

PLAN NAME ______________

SUBSCRIBER NAME ______________ DOB / / /

PLAN NAME

SUBSCRIBER NAME ______________ DOB / / /

EMPLOYMENT STATUS (CIRCLE)

F/TIME P/TIME UNEMP SELF EMP RETIRED

STUDENT P/TIME F/TIME

EMERGENCY CONTACT

NAME: ______________ RELATION ______________

ADDRESS ______________ CITY ______ ST ______ ZIP ______

HOME PHONE ( ) ______________

RELEASE OF INFORMATION

DO WE HAVE PERMISSION TO:

LEAVE A MESSAGE ON YOU ANSWERING MACHINE YES NO

LEAVE A MESSAGE AT YOUR PLACE OF EMPLOYMENT YES NO

DISCUSS YOUR MEDICAL CONDITION WITH ANY MEMBER OF YOUR HOUSEHOLD YES NO

IF YES NAME ______________

PATIENT FINANCIAL POLICY & Notice of Privacy Practices (HIPAA)

We have contracts with BCBS, Cigna, Medcost, Medicare, Tricare & United Healthcare. You are responsible for any copay's, deductibles and co-insurance related to the above named insurance companies. If we do not contract with your insurance payment in full is expected at time of visit. We will file the insurance for you as a courtesy. Your insurance will reimburse you. If examination of a biopsy by a pathologist is needed the pathology laboratory will file your insurance and bill you directly in the insurance does not pay them for their work. Please sign below if you understand the financial responsibilities of your visit.

Notice of Privacy Practices (HIPPA)

We are committed to keeping yor health information private, and we are required by law to respect your confidentiality. Our Privacy Practices are outlined in the waiting room notebook, If you have further questions, please ask our staff. I am informed of Dr. Glover's Notice of Privacy Practices. I know I have the right restrict how protected health information about me is used or disclosed. I authorize the release of medical inforamtion to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications & perscriptions

Signature of Patient or Responsible Party ______________