KNIGHT DERMATOLOGY INSTITUTE

Patient Registration Form

801 N. Orange Avenue, Suite 520 Orlando, FL 32801
1901 Lee Road Winter Park, FL 32789
1035 Primera Blvd, Suite 1041 Lake Mary, FL 32746

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: 07/01/2021

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