SOUTHSIDE DERMATOLOGY
MEDICAL ◆ SURGICAL ◆ COSMETIC
5801 E 41ST Street, Suite 200 ● Tulsa, OK 74135 ● Phone 918-760-0700 ● Fax 918-628-0700

Patients First & Last Name _____ **Middle Initial**_____ **Nickname** _____

Date of Birth _____ **SS#** _____| _____ | _____ **Marital Status**: _____ **Gender:** Male or Female

Address _____ **City** _____ **State** _____ **Zip** _____

Phone (Home) _____ **(Work)** _____ **(Cell)** _____ **Preferred Contact Method** _____

Email _____ **Pharmacy** (Name & Location) _____

Is okay to leave a voicemail on answering machine? □ **Yes** □ **No** Is okay to obtain prescription history from pharmacy? □ **Yes** □ **No**

Is it okay for photographs to be taken for medical records only (we will NOT publish or use promotional purposes) □ **Yes** □ **No**

Primary Care Physician (First and last name) _____ **Referring Physician** _____

Emergency Contact _____ **Phone #** _____ **Relationship** _____

Parent or Guardian of Minor Children

Parent/Guardian Name _____ Date of Birth _____ Phone # _____

Address (if different than patients) _____City_____State_____Zip_____

INSURANCE INFORMATION

Primary Insurance Carrier _____

Member ID _____

Group Number _____

Secondary Insurance Carrier _____

Member ID _____

Group Number _____

I UNDERSTAND THAT I AM RESPONSIBLE FOR THE PAYMENT OF ANY SERVICES AT TIME OF SERVICE.

I understand that I am responsible for all charges including deductible, co-pay's, etc. that are not covered by my insurance plan including Medicare. I authorize transfer of medical benefits to undersigned physician for services rendered. I authorize release of any medical information necessary to process this claim. **Please note**: you may incur separate charges for laboratory services.

No Show Policy: If 24 hours' notice of cancellation is not received, you will be charged $25 for the missed appointment.

Patient Signature _____ **Todays Date** _____

Notice of Privacy Practices Patient Acknowledgement

I have received and understand the practice's Notice of Privacy Practices written in plain language. I understand that the practice reserves the right to change the terms of its Notice of Privacy Practices. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Permission to Disclose Health Information

I grant permission for Southside Dermatology to discuss or release information concerning my medical diagnosis, or information relating to or in my medical records, or any medical information that the aforementioned entity may have on file as it concerns me including but not limited to billing, benefit inquiries, claims, and appeals and complaints, to the following individual/(s) in compliance with the required HIPAA guidelines:

Name: _____ **Relationship:** _____ **Name:** _____ **Relationship:** _____

Name: _____ **Relationship:** _____ **Name:** _____ **Relationship:** _____

Patient Signature _____ **Todays Date** _____