

720 W 71st Street S • Tulsa, OK 74132 • Phone 918-760-0700 • Fax 918-628-0700

Marital Status: Gender: Male or Fermal Address City State Zip	Patients First & Last Name			Middle InitialNickname			
Phone (Home)(Work)(Cell)	Date of Birth	SS#	Ma	rital Status:	G	ender: Male or Female	
Pharmacy (Name & Location)	Address		City	s	State	Zip	
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 No Primary Care Physician (First and last name) Referring Physician Relationship Relationship Parent or Guardian of Minor Children Phone # Relationship Phone # Address (if different than patients) Date of Birth Phone # Address (if different than patients) Phone # Address (if different than patients) State Zip State Zip Insurance Carrier Member ID Member ID Group Number Group Number Insurance Carrier Member ID Mem	Phone (Home)	(Work)	(Cell) Preferred Contact Method				
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 Referring Physician Referring Physician Relationship Regret of Contact Phone # Relationship Relat	Email	·	Pharmacy	(Name & Locatio	n)		
Primary Care Physician (First and last name)	Is okay to leave a voicemai	l on answering machine? \Box	Yes \square No Is oka	y to obtain prescri	iption history fron	n pharmacy? 🗆 Yes 🗆 No	
Phone # Relationship Parent or Guardian of Minor Children Parent / Guardian Name	Is it okay for photographs t	o be taken for medical reco	rds only (we will N	OT publish or use	promotional purp	oses) 🗆 Yes 🗆 No	
Parent/Guardian of Minor Children Parent/Guardian Name	Primary Care Physician (First		Referring Physician				
Parent/Guardian Name	Emergency Contact	mergency Contact		Phone # Re		Relationship	
INSURANCE INFORMATION Primary Insurance Carrier	Parent or Guardian of Min	or Children					
INSURANCE INFORMATION Primary Insurance Carrier Secondary Insurance Carrier	Parent/Guardian Name		Da	te of Birth	Phone #		
Primary Insurance Carrier Member ID Group Number 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 Medicar 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 Practicupon 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 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:	Address (if different than patien	nts)		City	State	eZip	
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Comp Number	Member ID						
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Todays Date _____

Patient Signature ____