Goodless Dermatology
Quality skincare for your entire family

Please verify that the following information is current, correct and fill in anything that is left blank. Thank you.

Today's Date: Demographics (1 of 2)

Patient Information:

Name:

Date of Birth: Circle One: Male Female

Address:

Email:

Contact Information:

MAY WE LEAVE DETAILED MESSAGES
(i.e. Appointments, Billing, Results, etc.)?

Home #: (____) _____	YES	NO	N/A
Mobile #: (____) _____	YES	NO	N/A
Work #: (____) _____	YES	NO	N/A
Would you like to receive Text Messages?	YES	NO	N/A

Family Information:

Primary Parent/Legal Guardian (*Primary Insurance Holder*)

Full name of Policy Holder (as it appears on insurance card): _____

Gender: ☐ Male ☐ Female Relationship to Patient: _____Phone #: _____

Date of Birth: _____/_____/_____

Other Parent/Legal Guardian:

Full Name: _____ Gender: ☐ Male ☐ Female

Relationship to Patient: _____ Phone #: _____

Marital Status: ☐ Married ☐ Divorced ☐ other: _____ *with whom does the patient reside? _____

* If all guardians do not reside at the address listed above, please provide a secondary address for statements information:

Address: _____ City: _____

State: _____ Zip Code: _____ Email Address: _____

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Today's Date:

Patient's Name: **Date of Birth:**

Please list any medical providers you would like to authorize to have access to your medical records.
These records will only be released upon your verbal request. You may revoke this authorization in writing at any time. By completing this section, you are authorizing Goodless Dermatology to release your medical record (including laboratory test results) to the Provider(s) listed.

Primary Care Physician: _____ Phone #: _____

Address: _____ Fax #: _____

Other Physician: _____ Phone #: _____

Address: _____ Fax #: _____

Were you referred to our office by a physician? Please circle: Yes No

If yes, Referring Physician: _____ Phone #: _____

Address: _____ Fax#: _____

Privacy Acknowledgment:

_____ **Initials**
We are required to protect your privacy
Our Notice of Privacy Policy (NPP) details your rights as a patient and how we may use and/or disclose your protected health information. Our NPP is available on our website and/or is furnished.

_____ **Initials**
We request all patients present a valid photo ID at each visit, unless we have it on file.
Your cooperation with HIPAA requirement is designed to protect your identity from misuse.

_____ **Initials**
Patients may revoke or change any provided authorizations at any time.
Please refer to our NPP for more details.

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Today's Date:

Patient's Name: **Date of Birth:**

Affordable Healthcare Act Questionnaire:

Race (Please circle only one)

I choose not to specify American Indian/Alaskan Native Asian White/Caucasian

Native Hawaiian/Other Pacific Island Black/African American Other: _____

Ethnicity (Please circle only one)

I choose not to specify Not Hispanic or Latino Hispanic or Latino

Preferred Language (Please circle only one)

I choose not to specify English Spanish American Sign Language Other: _____

Privacy Acknowledgment:

Social History:

Smoking Status: (Please circle one) Current smoker Former smoker Never smoked

Have you received an influenza immunization? YES NO

Please provide patient height: _____ and weight: _____