Michele M. Thompson, MD

DERMATOLOGY

DEMOGRAPHIC INFORMATION

Full Name: _____ Nickname: _____

Address: _____

Street City State Zip Code

D.O.B.:_____/_____/_____ Marital status:_____

Gender at birth: __Male __Female Gender identity: _____ *(optional)*

Communication:

Primary phone (____)_____-_____ [] cell [] home [] business

Secondary phone: (____)_____-_____ [] cell [] home [] business

Email:_____ [] I prefer to opt out of email communication

How do you prefer to receive appointment reminders: [] text [] email [] phone call

May we leave detailed messages, test results, or medical information on your voicemail? __Yes __No

Affordable Care Act: *Federal law mandates we ask these questions, but you may decline to answer.*

Race: _(decline) _White _Asian _Black AfrAm _Native Hawiian or PI _Am. Indian or Nat. Alaskan

Ethnicity: _(decline) _Hispanic or Latino _NOT Hispanic or Latino

Preferred language:_____

Emergency Contact: _____ Phone: (_____)_____-_____

Relationship: _____ [] cell [] home [] business

With whom do you give our office permission to discuss your medical information including appointments? __No One

Name: _____ Phone: (_____)_____-_____ Relationship:_____

Primary Care Physician: _____ Phone: (_____)_____-_____

Referring Physician: _____ Phone: (_____)_____-_____

How did you hear about us:_____

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IN ORDER TO BILL YOUR INSURANCE WE MUST HAVE THE SUBSCRIBERS INFORMATION BELOW

Primary Insurance:_____ Member ID Number: _____

Policy holder:_____

NAME DOB

Relationship to patient: __Self __Parent __Spouse __Other: _____

Secondary Insurance:_____ Member ID Number: _____

Policy holder:_____

NAME DOB

Relationship to patient: __Self __Parent __Spouse __Other: _____

FINANCIALLY RESPONSIBLE PARTY IF OTHER THAN SELF: _____

I attest that the information provided is to the best of my knowledge, true and accurate. I authorize Michele M. Thompson, MD LLC to release medical information necessary to process my insurance claim (if any). I hereby authorize payment of medical benefits to Michele M. Thompson, MD LLC when an assigned claim is filed. I understand that I am responsible for any amount not paid for by my insurance. I understand I am responsible for any known visit co-pays at the time of service.

By signing this form, I authorize the physicians, agents and employees of Michele M. Thompson, MD LLC to provide medical or surgical care and services, including, but not limited to, diagnostic tests, examinations and other medical and surgical procedures in the course of my medical care. I agree to comply with the plan of care/ services to which I have consented. I agree I have reviewed and understand the Notice of Privacy Practices (HIPAA). A paper copy has been offered to me.

I authorize Michele M Thompson, MD LLC and its providers to access my prescription medication history through Surescripts and other authorized pharmacy benefit and prescription history services. This information may include current and past prescription medications obtained from pharmacies and pharmacy benefit managers and will be used solely for purposes of treatment, care coordination, medication reconciliation, and patient safety. I understand that this authorization is voluntary and that I may revoke it at any time by notifying the practice in writing, except to the extent action has already been taken based on this authorization. I acknowledge that accessing my prescription history helps my healthcare providers make informed and safe treatment decisions.

_____ _____

Patient or Responsible Party Signature Date