EDMOND DERMATOLOGY CLINIC
620 W. 15th, Edmond, Oklahoma 73013

LEGAL NAME_____ SEX M or F BIRTHDATE_____

ADDRESS _____ CITY_____ZIP_____

PRIMARY PHONE_____PHONE_____PHONE_____ SOCIAL SEC. NO_____

EMPLOYER _____ OCCUPATION_____ MARITAL STATUS: M W D S

LANGUAGE_____ RACE_____ ETHNICITY- HISPANIC/LATINO: YES NO DECLINE

EMAIL: _____ Pharmacy/Location:_____

Primary Physician_____ Referring Physician_____

PRIMARY INSURANCE:

Insured's Name _____Date of Birth _____Social Sec No_____

Address _____City _____Zip _____

EMPLOYER_____Relationship to Patient _____

SECONDARY INSURANCE:

Insured's Name _____ Date of Birth _____ Social Sec No_____

Address _____ City _____ Zip _____

EMPLOYER _____ Relationship to Patient _____

By signing, you are agreeing to:
1) OFFICE VISIT CO-PAYS ARE DUE AT THE TIME OF CHECK-IN
2) If SELF PAY, all payment is due at time of service unless prior arrangements have been made.
3) authorize payments directly to Dr. Michael D. John
4) Be responsible for any portion of my bill not covered by my insurance company
5) authorize release of information for insurance claim purposes. **(May include release of communicable, venereal, or auto immune diseases)**
6) HIPAA privacy regulations are posted at check in area or are available upon request.
7) I give you and any of your agents, permission to contact me at any phone number that I have provided to you, including all cell phone numbers(which could result in charges to me), for the purpose of collecting my debt. I also give permission to contact me by sending text messages or e-mails, using the e-mail address I provided. Methods of contact may include using pre-recorded/ artifical voice messages and/or use of an automatic dialing device, as applicable.
8) Additional **COLLECTION** charges are the responsibility of the insured.

- **RELEASE OF PROTECTED HEALTH INFORMATION FOR EDMOND DERMATOLOGY CLINIC**: (ONLY IF 18 OR OLDER)

  Please identify the person/persons you authorize your protected health information (oral or recorded information) to be released to by EDC.

  NAME _____ RELATIONSHIP _____

  _____ _____

  _____ _____

- **EDC IS REQUIRED TO HAVE YOUR PERMISSION TO LEAVE MESSAGES REGARDING YOUR PROTECTED HEALTH INFORMATION (TEST RESULTS, LAB & PATHOLOGY, INSTRUCTIONS, MEDICATION INFORMATION)**

  ☐ YES, EDC May leave a message on my voicemail/answering machine

- **EMERGENCY CONTACT**:
  Name: _____ Phone Number: _____

I UNDERSTAND ALL OF THE ABOVE AND HEREBY STATE THAT THEINFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE

- I further understand and agree that my signature to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release future information shall remain in force no longer than 12 months or until such time as I shall REVOKE it in writing.

PATIENT SIGNATURE: _____ DATE _____

_____ DATE _____

_____ DATE _____

_____ DATE _____

_____ DATE _____