# Tideway Dermatology, PA

Dermatology and Dermatologic Surgery
930 Revolution Street, Havre de Grace, MD 21078-3201
615 W. MacPhail Road Ste 212 Bel Air, MD 21014
Phone (410)939-0961

**Patient Information Form**

Please fill out the following information. All information is strictly confidential. Please print.

PATIENT NAME: _____
(Last) (First) (Middle Initial)

DATE OF BIRTH: _____AGE: _____ MALE: _____ FEMALE: _____ SS #: _____

HOME ADDRESS: _____
(street) (city/state/zip code)
MAILING ADDRESS (if different from above): _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

WHAT IS THE PREFERRED PHONE NUMBER WE SHOULD USE TO CONTACT YOU? _____
IS IT OK FOR US TO LEAVE A DETAILED MESSAGE ON THIS NUMBER? _____

EMAIL ADDRESS: _____EMPLOYER NAME/ADDRESS:_____

MARITAL STATUS: _____ SPOUSE'S NAME: _____ SPOUSE'S WORK/CELL PHONE: _____

WHO SHOULD WE CONTACT IN THE EVENT OF AN EMERGENCY?: _____ PHONE: _____

NAME OF PHYSICIAN WHO REFERRED YOU TO OUR OFFICE: _____

NAME/NUMBER/ZIP CODE OF PREFERRED PHARMACY: _____

**Guarantor/Responsible Party information (if under 18):**

NAME: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

EMPLOYER'S NAME AND ADDRESS: _____

**Patient's authorization:**

I hereby authorize Tideway Dermatology, PA to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company be made directly to Tideway Dermatology, PA. I certify that the information I have reported with regard to the insurance coverage is correct and further authorize the release of any necessary information including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided when a statement is rendered. I consent to the treatment necessary for the care of the above named patient. I authorize the release of all medical records to a physician and/or my insurance carrier when this office is presented with a valid medical records request. I understand that payment in full of charges, copayment, coinsurance and deductible amounts is due at the time of service unless other financial arrangements have been made *prior* to treatment. Also, I understand and agree that if I miss a scheduled appointment without giving 24 hours notice of cancellation I will be charged $50.00 for that appointment. My signature indicates I acknowledge this office has notified me in writing of this practice's HIPAA policy. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Signature of patient or guarantor/responsible party: _____ Date: _____

Name of guarantor/adult filling out this form: _____ Phone: _____

What is your relationship to this patient?: _____

**PLEASE COMPLETE THE INSURANCE AND HIPAA INFORMATION ON THE REVERSE SIDE OF THIS PAGE. THANK YOU!**