KNOTT STREET
DERMATOLOGY

Name_____
(LAST) (FIRST) (MI)

Date of Birth _____ **SSN**_____ **Sex**_____

Ethnicity (circle all that apply) American Indian/Alaska Native Asian Black or African American
Hispanic Native Hawaiian Other Pacific Islander White Other_____

Preferred Language: _____ **Will you require an interpreter?** _____

Mailing Address _____ **City/ST/Zip** _____

Home Phone_____ **Cell Phone**_____ **Work Phone**_____

Employer/Occupation _____

Email Address _____ **Primary Care Physician** _____

Preferred Pharmacy Name & Location _____

Guarantor (Subscriber of Insurance Plan)

Name _____ **Date of Birth** _____ **Relation** _____

SSN _____ **Sex** _____ **Phone Number** _____

Address (if different than patient's) _____ **City/ST/ZIP**_____

CONSENT FOR TREATMENT: I authorize Knott Street Dermatology and its personnel to provide ongoing medical care, treatment, and procedures (skin biopsies, routine surgical skin procedures, etc.) as ordered by the physicians and/or other health care providers. Most tissue and cultures are sent to outside laboratories, if my insurance carrier(s) requires a specific facility, I will let staff know at the time service is rendered. I acknowledge that no guarantee can or will be made as to the results of the care, treatment, and medication prescribed.

CONSENT FOR RELASE OF INFORMATION: I authorize Knott Street Dermatology to release to my insurance carrier(s) including Medicare, Medicaid, and any other reimbursing agency, information about my identity, treatment, diagnosis, prognosis, and/or services rendered (including drug/alcohol abuse treatment, mental health treatment; diagnosed and/or treatment of HIV, AIDS, AIDS-related illness, or sexually transmitted disease/infection) as permitted by state and federal law which may be required or requested, thus releasing Knott Street Dermatology from any liability for furnishing such information. I understand information may be released through electronic and/or paper media

PRESCRIPTION REFILL POLICY: Knott Street Dermatology maintains a policy requiring all patients to be seen within one year of a prescription release date to refill a prescription.

Signature of Patient (Or Legally Authorized Representative) Date