Eric Hanson, MD
Craig Schultz, FNP-RN

KNOTT STREET DERMATOLOGY

Charles Mauro, MD
Mara Limoncelli, PA-C

Child's Name____
(LAST) (FIRST) (MI)

Date of Birth _________________ **Sex**__________ Primary Care Physician____________________________

Patient Mailing Address_______________________________________ **City/ST/Zip**___________________________

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? _________

Preferred Pharmacy Name & Location ____

Parent/Guardian Name____ **Relationship**______________________

Parent/Guardian Mailing Address___________________________________**City/ST/Zip**________________________

Home Phone____________________ **Cell Phone**____________________ Work Phone________________________

Parent/Guardian Email__________________________________ **Parent/Guardian SSN**______________________

PRIMARY Insurance

Name of **Person** who holds Insurance Policy____

Date of Birth _________________ **Relationship** __________________ SSN __________________ Sex _________

Address (if different than patient's) ________________________________ City/ST/ZIP________________________

SECONDARY Insurance

Name of **Person** who holds Insurance Policy ____

Date of Birth _______________ **Relationship** _______________ SSN ________________________ Sex _________

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.

X
____
Signature of Responsible Party Date

____
Print Name of Responsible Party Relationship