SONTERRA DERMATOLOGY

Patient Information

PLEASE PRINT CLEARLY

DATE_____ EMAIL_____

Name_____Male_____Female_____

Birth date_____Age_____Social Security #_____

Address_____Minor_____Single____Married_____Widowed____Other _____

City_____State_____Zip _____

Home Phone_____Work #_____Ext_____Cell #_____

Employer_____Occupation_____Student: FT_____PT_____

Race_____Ethnicity_____Language_____

Referred by: First Name_____Last Name _____

(Who is Responsible for account?)

Name_____Relationship to patient_____

Birthdate_____Driver's License # _____Social Security # _____

Address_____City_____State_____Zip _____

(In the event of an emergency, who should we contact?)

Name_____Relationship_____Work #_____Home # _____

PRIMARY INSURANCE

Name of Insured_____Birthdate_____Social Security # _____

Employer_____Name Of Insurance _____

ID Number_____Group Number _____

SECONDARY INSURANCE

Name of Insured_____Birthdate_____Social Security # _____

Employer_____Name of Insurance _____

ID Number_____Group Number_____

PAYMENT POLICY: All professional services rendered are charged to the patient. The patient is responsible for payment regardless of insurance coverage. Full payment is expected at time of each office visit unless arrangements have been made in advance. Billing information will be provided to expedite payment reimbursement from private carriers.

AUTHORIZATION OF PAYMENT: I hereby authorize the provider to release medical information concerning my examination and/or treatment for insurance purposes and to receive direct payment for medical benefits payable to me for services rendered.

X _____

Signature of patient or parent if minor Date

Sonterra Dermatology
325 Sonterra #110 San Antonio, Texas 78258
Office: 496-5792 Fax: 496-7601

Notice and Acknowledgment

I acknowledge that I have received a brochure providing the following information and have been given the opportunity to read and ask questions to assure that I understand their contents. I understand that by signing this form, I consent to the provisions of my patient rights, patient responsibilities and the sharing of information as indicated by the Notice Of Privacy Practices.

- ✓ **Notice of HIPAA Privacy Practices**
- ✓ **Patient Responsibilities**
- ✓ **Patient Rights Regarding Health Information**

_____ _____
Printed Name of Patient/guardian Date

_____ _____
Signature of Patient/guardian Date

SONTERRA DERMATOLOGY

325 E. Sonterra Blvd., Suite 110
San Antonio, TX 78258

Please list the family members or other persons, if any, with whom we may discuss your general medical condition and/or your diagnosis:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Please print the telephone number where you want to receive calls about appointments, lab or test results, billing, insurance inquiries, or other health care information.

Phone ( ) _____-_____

May confidential messages (appointments, lab or test results, billing, insurance inquiries) be left on the answering machine or voicemail at the telephone number provided above.

YES _____ **NO** _____

I understand that this agreement remains in effect until revoked by me in writing. If I revoke my consent, such revocation will not affect any actions that Sonterra Dermatology took before receiving my revocation.

_____ _____
Patient or Legal Representative Signature Date

_____ _____
Guardian Signature if under 18 years of age Date