Welcome! This questionnaire collects information about your contact, insurance and pharmacy preferences in order to assist the physicians and staff with your care and to allow them meet requirements established by Medicare and other insurers. This information and your signature will be stored electronically and incorporated into your medical record.

Answer **ALL** questions by filling in the appropriate circle(s) and/or by **PRINTING** the requested information in the appropriate box.

Patient Name: _____ Birth Date: _____-_____-_____

Minors (under age 18): Parent/Legal Guardian: _____

Preferred Phone: (_____)_____ Text reminders allowed? 0 Yes 0 No

Address: _____ City/State/Zip: _____

Emergency Contact: _____ _____
(Name) (Emergency Contact Telephone)

Individual(s) with whom we can message/share your private health information (spouse/partner etc.):

_____ _____ _____
(Name/Contact Info.) (Name/Contact Info.) (Name/Contact Info.)

Patient Email: _____ Email messages allowed? 0 Yes 0 No

Referring Provider: _____ _____
(Name) (City and/or phone #)

Preferred Pharmacy: _____ _____
(Pharmacy City or Store #)

Your signature affirms that the above information is accurate to the best of your knowledge

Signature: _____ Date: _____

Each patient (or guardian) is provided a comprehensive outline of the <u>private health information policy</u> and <u>financial policy</u> of Nashville Dermatology Physicians.

Upon review your signature acknowledgement will be electronically signed and saved into your medical record.

All policies of Nashville Dermatology Physicians will require review and reaffirmation once yearly.