Carla J. Bauman M.D. Medical and Cosmetic Dermatology

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PATIENT INFORMATION- PLEASE PRINT AND COMPLETE FORM PRIOR TO APPOINTMENT

PATIENT NAME:____
LAST FIRST MIDDLE

PREFERRED NAME:____________________________ **MARITAL STATUS**: Single / Married / Partner / Divorced / Separated / Widowed

BIRTH DATE: ____________________ **SEX**: M F **EMAIL**: ______________________________
MM/DD/YY

By including your email you are authorizing Carla J. Bauman staff to send an invitation to the Patient Portal allowing access to medical records, this must be accepted within 24 hours of receipt.

ADDRESS:____
STREET ADDRESS CITY STATE ZIP

PRIMARY PHONE#:________________ **ALT. PHONE#**:________________ **WORK. PHONE #**: ________________

RACE: ___ American Indian/Alaska Native___ Asian___ Black/African American___ Native Hawaiian or Pacific Islander
___White ___Other Race **ETHNICITY**: ____ Hispanic/Latino____ Non-Hispanic/Latino____ Declined

PRESENT EMPLOYER: ______________________________________

If other than patient:

RESPONSIBLE PARTY NAME: ________________________ **RELATIONSHIP TO PATIENT**:________________
LAST, FIRST

ADDRESS: ____
STREET ADDRESS CITY STATE ZIP PHONE

MARITAL STATUS: Single / Married / Partnered / Divorced / Separated / Widowed

How did you hear about Carla J Bauman Medical and Cosmetic Dermatology? □ Family □ Friend □ Doctor
□ Other:____

EMERGENCY CONTACT: ____
LAST, FIRST RELATIONSHIP PHONE

REFERRING PHYSICIAN:____
NAME LOCATION PHONE

INSURANCE INFORMATION

PRIMARY INSURANCE: ________________ **SUBSCRIBERS NAME**: ________________ **DATE OF BIRTH**:____________
ID#____________________ **GROUP#**____________________
PATIENT RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD OTHER
SECONDARY INSURANCE: ________________ **SUBSCRIBERS NAME**:________________ **DATE OF BIRTH**:____________
ID#____________________ **GROUP#**____________________
PATIENT RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD OTHER

Notice of Privacy Practices-Acknowledgement

We keep a record of the health care services we provide you. You may request to see, receive and/or make corrections to that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. To request a copy of your records or for more information contact the office at 425-455-3376. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. You may request a complete copy of our Notice of Privacy Practices or access it via our website at www.cjbmd.com

Release of Benefits and Information

Life Time Authorization: I authorize my insurance benefits be paid directly to Carla J. Bauman, MD for any services furnished to me by Carla J. Bauman, MD Medical and Cosmetic Dermatology Healthcare Professional. I am responsible for any balance due along with balances due for cosmetic procedures. I authorize any holder of medical information of my own to release to my insurance company and its agents any information needed to determine benefits or the benefits payable for related services.

Our office asks for a 24 hour notice to reschedule or cancel appointments. Failure to comply will result in a $50 medical visit/$75 Cosmetic visit No Show/Late Cancellation Fee. If an emergency arises, please give us as much notice as possible.

By signing you are acknowledging that you have completed this form to the best of your knowledge, you have read the Notice of Privacy Practices statement; you have read the release of Benefits Information and understand our Cancellation policy.

______________________ ______________________ ________________ __________
PRINT PATIENT NAME PATIENT OR AUTHORIZED LEGAL SIGNATURE RELATIONSHIP TO PATIENT DATE