Akron Dermatology
Eliot Mostow, M.D.~ Terri Nagy, PA-C
566 White Pond Drive, Suite E
Akron, Ohio 44320
Phone: 330-535-7100 Fax: 330-535-2600

NEW PATIENT REGISTRATION FORM

DATE_____

(PLEASE PRINT)

NEW PATIENT INFORMATION

PATIENT NAME: LAST NAME	FIRST NAME	MIDDLE INIT	SEX ○M ○F	BIRTH DATE	AGE

STREET ADDRESS	CITY	STATE	ZIP CODE	PHONE

SS#	EMAIL ADDRESS	MARITAL STATUS: ○S ○M ○W ○D ○SEP

EMPLOYER	CITY	STATE	ZIP CODE

Race:
○ Caucasian ○ Other
○ Hispanic ○ Decline
○ African American

Ethnicity:
○ Non-Hispanic
○ Hispanic
○ Decline

Primary Language:
○ English ○ Other
○ Spanish ○ Decline

☐ Same as patient (above)

RESPONSIBLE PARTY INFORMATION

NAME: LAST	FIRST	MIDDLE	SEX ○M ○F	DATE OF BIRTH

STREET ADDRESS	CITY	STATE	ZIP CODE	PHONE

SS#	EMPLOYER	OCCUPATION	BUSINESS PHONE

IN CASE OF EMERGENCY PLEASE CALL

LAST NAME	FIRST NAME	RELATIONSHIP TO YOU	PHONE

DOCTOR WHO REFERRED YOU

LAST NAME	FIRST NAME	PHONE

FAMILY OR PRIMARY CARE PHYSICIAN

LAST NAME	FIRST NAME	ADDRESS

PHARMACY

NAME	PHONE

AUTHORIZATION FOR PAYMENT OF BENEFITS / RELEASE MEDICAL INFORMATION

I request that payments from my insurance company (companies) be made directly to AKRON DERMATOLOGY. I understand that I am responsible for any balances that may be incurred from deductibles or un-allowed services from my insurance company. I further authorize release of any necessary medical information to determine benefits. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The patient understands that: Protected health information may be disclosed or used for treatment, payment or health care operations, The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.

We do not send any fundraising communications so you are automatically opted out of that HIPAA option. **We do run occasional promotions for product and cosmetic procedure sales. If you would like to be included in these, please list your preferred email:** _____ **or Check here** ☐ **to opt out and not receive this information via email.**

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PREFERRED AND PERMITTED CONTACTS

For _____
(PLEASE PRINT NAME)

Please help us to communicate with you!

HOME _____ NUMBER
- ☐ Can leave detailed message
- ☐ Leave call back information only
- ☐ No Messages at this number

WORK _____ NUMBER
- ☐ Can leave detailed message
- ☐ Leave call back information only
- ☐ No messages at this number

CELL _____ NUMBER
- ☐ Can leave detailed message
- ☐ Leave call back information only
- ☐ No messages at this number

☐ I give permission to be contacted by email: _____

◯ I give permission to share test results/other information with my spouse/parent/other.

◯ Speak only to me regarding any results/information.

Persons allowed to speak with:

NAME	RELATIONSHIP	PHONE

☐ By checking this box, you are agreeing to the release of medical information/HIPAA consents in lieu of signature. We are required to collect this data to be in compliance with Medicare's requirements for Electronic Medical Records and HIPAA regulations.

Agreed to by: _____

☐ I am the parent or guardian of the patient.

Submit Form