Print Form

New Patient Registration

Tiffani K. Hamilton, MD

Atlanta Dermatology, Vein & Research
11800 Atlantis Place
Alpharetta, Georgia 30022
770-360-8881
fax 770-255-2533

PATIENT

Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Email Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

Soc. Sec # _____ Prior Name _____

Marital Status ◯ Single ◯ Married ◯ Divorced ◯ Widowed Sex ◯ Male ◯ Female

Employer _____ Occupation _____

Employer Address _____ Employer Phone Number _____

Select prefered method for confidential communication: ◯ Cell ◯ Home ◯ Work ◯ Email

Preferred Language _____

Ethnicity and Race: ◯ American Indian or Alaska Native ◯ Asian ◯ Black or African American ◯ Other Race
◯ Native Hawaiian or Other Pacific Islander ◯ White Non-Hispanic ◯ Hispanic or Latino

RESPONSIBLE PERSON *(IF DIFFERENT FROM PATIENT)*

Name _____ Phone Number _____ Relationship _____

Address _____

Phone Number _____ Soc. Sec # _____ Date of Birth _____

Employer _____ Employer Phone Number _____

INSURANCE INFORMATION

Name of Insured _____ Date of Birth _____ Relationship _____

Insurance Company _____ Group Number _____

Claims Address _____ ID Number _____

EMERGENCY CONTACT

Name _____ Phone Number _____ Relationship _____

Date of Birth _____

Address _____

How were you referred to our office?: ◯ Family Member ◯ Physician ◯ Friend ◯ Internet ◯ Other

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DERMATOLOGY

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Preferred Contact Method

How do you wish to be contacted by our office? (please select all that apply)

☐ I request to be contacted regarding my treatment via text message or cell phone.**

My preferred cell phone number is: _____

☐ I request to be contacted regarding my treatment via email through our secure patient portal.**

My preferred email address is: _____

☐ I request to be contacted regarding my treatment by phone. I understand that messages regarding my treatment will be left at this number should I be unavailable to answer the call.

My preferred phone number is: _____ ☐ home ☐ work ☐ cell

I authorize you to discuss my care and treatment with the following individual(s):

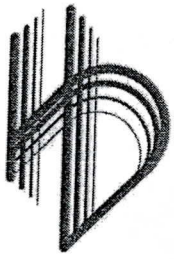
_____ relationship: _____

_____ relationship: _____

** I understand that text messages and email sent outside the patient portal are NOT secure forms of communication. **I will NOT hold Hamilton Dermatology liable for any accidental disclosure of protected health information through these forms of communication.**

_____ _____
Patient Name – Printed Patient Date of Birth

_____
Signature of Patient or Responsible Party



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Receipt of Notice of Privacy Practices and Office Policies

NPP Revision Date: **August 6, 2005**

I have received a copy of the Notice of Privacy Practices and Office Policies. I understand that if I have any questions regarding these policies, I can contact the office manager at 770-360-8881.

_____
(Signature of Patient or Legal Representative)

_____
(Print Name of Patient)

_____
(Date)