MICHELE M. THOMPSON, M.D.

DERMATOLOGY

DEMOGRAPHIC INFORMATION

Full Legal Name:____ DOB:____________

Preferred Name (i.e. nickname):______________________________

Mailing Address:____
Street City State Zip Code

Email:______________________________________ ◻ I prefer to opt out of email communication

Primary phone: (______)______-________ ◻ cell ◻ home ◻ business

Secondary phone: (______)______-________ ◻ cell ◻ home ◻ business

How do you prefer to receive appointment reminders? ◻ text ◻ email ◻ phone call

May we leave detailed messages, test results, and/or medical information on your voicemail? ◻ Yes ◻ No

Gender: ◻ Male ◻ Female Marital status:_____________

Affordable Care Act: *Federal law mandates we ask these questions, but you may decline to answer.*

Race: ◻ White ◻ Asian ◻ Black/African American ◻ Native Hawaiian/Pacific Islander
◻ Am. Indian or Nat. Alaskan ◻ Other:_____________________ ◻ Decline

Ethnicity: ◻ Hispanic or Latino ◻ NOT Hispanic or Latino ◻ Decline

Preferred language:_______________________ Do you need an interpreter? ◻ Yes ◻ No

Emergency Contact:_________________________________ Relationship:________________________

Phone: (______)______-________ ◻ cell ◻ home ◻ business

With whom do you give our office permission to discuss your medical information? ◻ No One

Name:__________________________ Relationship:________________ Phone: (______)______-________

Primary Care Physician:_____________________________________ Phone: (______)______-________
First Name Last Name

Referring Physician:____ Phone: (______)______-________
First Name Last Name

How did you hear about us?____________________________

MICHELE M. THOMPSON, M.D.

DERMATOLOGY

<u>IN ORDER TO BILL YOUR INSURANCE WE MUST HAVE THE SUBSCRIBER'S INFORMATION</u>

Primary Insurance:____ Member ID:_____________________________

Policyholder:____ DOB:___________________________________
Name

Relationship to patient: □ Self □ Parent □ Spouse □ Other:________________________________

Secondary Insurance:_______________________________________ Member ID:_____________________________

Policyholder:____ DOB:___________________________________
Name

Relationship to patient: □ Self □ Parent □ Spouse □ Other:________________________________

Financially Responsible Party if other than self:

Name:____ Relationship:________________________

I attest that the information provided above is to the best of my knowledge, true and accurate. I authorize Michele M. Thompson MD LLC to release medical information necessary to process my insurance claim (if any). I hereby authorize payment of medical benefits to Michele M. Thompson MD LLC when assigned claim is filed. I understand that I am responsible any amount not paid for by my insurance. I understand I am responsible for any known visit co-pays at the time of service.

By signing this form, I authorize the physicians, agents and employees of Michele M. Thompson MD LLC to provide medical and/or surgical care and services, including, but not limited to, diagnostic tests, examinations and other medical and surgical procedures in the course of my medical care. I agree to comply with the plan of care/ services to which I have consented. I agree I have reviewed and understand the Notice of Privacy Practice (HIPAA). A paper copy has been offered to me.

____ ____________________________

Patient or Responsible Party Signature Date