BALSHI®
BEAUTY. DERMATOLOGY. COSMETICS.

PATIENT INFORMATION

Name (First, Middle, Last): Date of Birth: Sex: ☐ M ☐ F

Address: City / State / Zip:

SS #: Marital Status: Preferred Name: Email:

Home #: Cell #: Cell Carrier: Work #:

PRIMARY INSURANCE HOLDER

☐ Check here if you are the primary

Name: Date of Birth: SS #:

Address: City / State / Zip:

Employer: Work #: Home #: Cell #:

HOW WERE YOU REFERRED TO OUR OFFICE?

Doctor Name: Patient Name:

Internet: Other:

CONSENT TO TREATMENT / FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examination, and treatment.

I hereby assign, transfer, and set over to Thomas Balshi all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any, medical, information needed to determine these benefits. This authorization shall valid until written notice is given to me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

I certify that I have read this form and understand its contents. E-signatures are legally binding.

Patient or Other Legally Authorized Person: Date:

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PCP/INTERNIST INFORMATION

Name of Doctor: _____ Phone: _____ Fax: _____

Address: _____ City / State / Zip: _____

MEDICAL INFORMATION

List Your Current Medication(s): _____

_____

List Your Allergies to Medication(s): _____

List Important Medical History/Surgeries: _____

Pharmacy Name & Number: _____

***The following names are the people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Thomas Balshi, M.D., P.A., to share my protected health information with:**

_____ _____

Name / Relationship to Patient Name / Relationship to Patient

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I have been provided with a Notice of Privacy Practices that provides me a more complete description of he uses and disclosures of certain health information. I understand that Thomas Balshi, M.D., P.A., reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an undated copy. I may request a copy in person at my appointment.

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to disclosure of any medical information. I understand that e-signatures are legally binding.

_____ _____ _____

Patient's Printed Name Patient / Legal Representative Signature Date

RELATIVE/FRIEND TO CONTACT IN CASE OF EMERGENCY

Name: _____ Phone: _____ Relationship: _____

I wish to be contacted in the following manner: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Okay to leave message with detailed information: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email