PATIENT REGISTRATION FORM

J. Matthew Knight, M.D.
801 N. Orange Avenue, Suite 520, Orlando, FL 32801
Phone (407) 992-0660 / Fax (407) 992-7702

Name____ Date of Birth ______/______/______
Last First MI

SSN ______________________ Email ______________________

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Prefer Not to Specify

Race: □ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or Other Pacific Islander □ White □ Prefer Not to Specify

□ Male □ Female

Preferred Language ______________________

Marital Status ______________________

Home Address____
City State Zip Code

Mailing Address____
(If different from home address) City State Zip Code

Home Phone (______) ____________ Work Phone (______) ____________ Cell Phone (______) ____________

Employer______________________ Occupation______________________

PARENT OR RESPONSIBLE PARTY (If Different From Patient)

Name____
Last First MI

Date of Birth ______/______/______ Sex__________ SSN______________________

Address____
City State Zip Code

Home Phone (______) ____________ Work Phone (______) ____________ Cell Phone (______) ____________

INSURANCE INFORMATION (Please Present Insurance Card at Time of Check-In)

Primary Insurance Name______________________

Name of Policy Holder______________________

DOB____/____/____ SSN of Policy Holder______________________

Insured's ID No.______________________

Group No.______________________

Relationship of Patient to Policy Holder______________________

Secondary Insurance Name______________________

Name of Policy Holder______________________

DOB____/____/____ SSN of Policy Holder______________________

Insured's ID No.______________________

Group No.______________________

Relationship of Patient to Policy Holder______________________

Person to contact in case of emergency ______________________

Address____ Phone (_____) ______________

Were you referred by a physician? □ Yes □ No **If yes, please list name of physician here:** ______________________

If not, who is your primary care physician (PCP)? ______________________

I hereby request the professional services of J. Matthew Knight, M.D., and agree to financial responsibility as indicated in the paragraph below:

I understand that Knight Dermatology Institute will only file insurance claims to plans in which they participate. If I am covered by a plan that they do not participate in, payment will be expected of me at the time of service. I authorize the release of medical information necessary to process claims, and also authorize payment of medical benefits to the physician. If my insurance does not pay, I will be financially responsible for payment in full.

Signature of Patient or Legal Guardian____ Date______/______/______

Please indicate how we may contact you regarding appointments, follow up, biopsy results, lab results, etc:

□ **May we call you at:** □ Home Number □ Cell Number □ Work Number

(May we leave a message at: □ Home Number □ Cell Number □ Work Number)

□ **May we email you**

May we email you regarding promotions or specials: □ Yes □ No

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May we discuss your medical condition or health record with a member of your household:
□ Yes (*You must fill out below*) □ No

If yes, whom: ______________________________

Relationship: ______________________________

Please indicate any other directives you may have regarding your health record or how we may contact you:

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______________________________ ______________
Signature of patient or patient representative Date

______________________________ ______________
Printed name of patient or patient representative Relationship to Patient

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J. MATTHEW KNIGHT, MD, PA
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: 08/26/2013

I have received a copy of the Notice of Privacy Practices (the "Notice") of J. Matthew Knight, MD, PA (the "Company"). The Notice describes how my protected health information may be used or disclosed. I understand that I should read it carefully. In addition, I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling the Company or the Company's Privacy Officer at 407.992.0660, on the Company's website at www.knightdermatology.com, or by requesting one at the Company's offices.

______________________________ ______________
Signature of patient or patient representative Date

______________________________ ______________
Printed name of patient or patient representative Relationship to Patient