



Henry Dorn, MD & Associates
 405 Lindsay Street
 High Point, NC 27262-4829
 Phone 336-889-2000
 Fax 336-889-2050

Date _____

Patient Name: _____ Social Security Number: _____

Date of Birth: _____ Sex: Female _____ Marital Status: S ___ M ___ D ___ W ___ Primary Language _____

Maiden Name: _____ Street Address: _____

Apt. No.: _____ City: _____ State _____ Zip Code: _____

Home phone: (____) _____ Work phone: (____) _____ Cell/Pager number: (____) _____

Email Address: _____ Patient Employer _____

Emergency Contact relationship _____ Emergency Contact Name: _____

Emergency Contact Phone: (____) _____ Referred by _____ Preferred Pharmacy _____
(name and location)

Permission to leave appointment information on phone number listed and/or email (check one) yes no
 For **email communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.

Race: White Asian African-American American-Indian Other _____ Primary Language _____

Primary Insurance Company's Name: _____ Name of Policy Holder _____

Affordable Care Act Policy? YES _____ NO _____

Insurance ID# _____ Group Number _____

Primary Care Physician _____ Phone (____) _____

Relationship to Patient: _____ Responsible Party Date of Birth: ___/___/_____

Guarantor's Social Security Number: _____ - _____ - _____

Guarantor's Address: _____ Apt. No.: _____ State _____ Zip Code: _____

Home phone: (____) _____ Cell/Pager number: (____) _____

Insured's employer's Name: _____ Work Phone: (____) _____

Employer's Address: _____ City: _____ State _____ Zip Code: _____

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE/MEDICAID/INSURANCE BENEFITS BE MADE DIRECTLY OR ON MY BEHALF TO DR HENRY DORN, MD, FURNISHED TO ME BY THAT SUPPLIER. I AUTHORIZE ANY HOLDER OF HOSPITAL OR MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS AND CARRIERS AS WELL AS TO DR HENRY DORN, MD, ANY INFORMATION OR DOCUMENTATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. I UNDERSTAND THAT THIS AUTHORIZATION MAY BE USED BY THE SUPPLIER FOR ALL SERVICES IN THE FUTURE UNTIL SUCH TIME AS I REVOKE THIS AUTHORIZATION IN WRITING.

 SIGNATURE AND CONSENT TO PAY DIRECTLY

 DATE

Consent for Laboratory/Pathology Services

I have been informed that there may be a series of blood work or urine specimens collected for diagnostic purposes.

I consent to the medical care and treatment by Henry H Dorn, MD and Associates and agree to be responsible for the cost of such treatment and testing. All specimens are sent to Solstas Laboratory and I will be responsible for paying Solstas Laboratory directly for any amounts not covered by insurance.

Signature: _____ Date _____