Henry Dorn, MD & Associates
405 Lindsay Street
High Point, NC 27262-4829
Phone 336-889-2000
Fax 336-889-2027

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 and may contain health information, via test results and/or billing statements. I still elect to move forward to allow email communications to occur.

Race: White Asian African-American American-Indian Other________________ Primary Language_______________________

Primary Insurance: (circle one) Aetna BCBS CIGNA MedCost Medicaid UHC Other__________________________

Affordable Care Act Policy? YES______________ NO________________

Primary Care Physician__________________________________ Phone (___)_____________________________________

Guarantor's Name : ___________________________________ Guarantor's Date of Birth: ___/___/______

Guarantor's Social Security Number: _______ - _____ - _________Relationship to patient: ___________________________

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 Pathgroup Laboratory and I will be responsible for paying Pathgroup Laboratory directly for any amounts not covered by insurance.

Signature: ____ Date______________________________