PATIENT INFORMATION FORM

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Certified by American Board of Dermatology
General and Aesthetic Dermatology-Mohs Surgery

Patient's Name: _____ Date of Birth: ___/___/_____
Address: _____ City/State/Zip: _____
Gender (Circle one): M F Prefer Not To Say How Do You Wish To Be Addressed? _____
Home Phone: (_____) _____ Cell: (____) _____ Preferred Phone (Circle one) Home Cell
May we leave a detailed message on your answering machine including results on preferred phone? (Circle one) Yes No
Email: _____ Interested in emails for cosmetic offers? (Circle one) Yes No
Marital Status: _____ Employer: _____
Race: (Circle One) White American Indian Asian African American Hawaiian Other: _____
Ethnicity: (Circle One) Hispanic or Latino Not Hispanic or Latino Unknown
Pharmacy name, city, street:_____ _____
Primary Care Physician (first and last name): _____

If you are not the subscriber to your insurance: (Circle One) Primary Secondary Both
Subscriber Information Name: _____ Date of Birth: ___/___/____ Cell: (____) _____
Address: _____ City/State/Zip: _____ Relationship to Subscriber: _____

Emergency Contact (First Name, Last Name, Phone #): _____
I give permission to discuss medical information with the following:
#1 Name: _____ Relationship: _____
#2 Name: _____ Relationship: _____

BILLING POLICY

- All co-pays must be paid at the time of service. If you are unsure as to your correct co-pay amount, please contact your insurance company by calling the member service phone number on your card.
- Coinsurance and deductible amounts are due in full within 30 days of the first statement received. If needed, please contact our office with any billing questions.
- There will be a $25.00 charge for any returned checks.
- You will be given a separate billing policy for any cosmetic appointment deposits.

By signing this form you are verifying that you have read this notice and have provided the office with accurate and current information needed to process your medical claims.

*If you would like a copy of the signed form, please ask the receptionist.

PATIENT SIGNATURE: _____ DATE: _____