

# NEW PATIENT INFORMATION

## PERSONAL INFORMATION

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ (if PO Box also give street address please)  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Sex  Male  Female  Other  
Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_  
Email Address: \_\_\_\_\_

## BIOPSY INFORMATION

Can we leave medical information or test results on your answering machine or voice mail?  Yes  No  
Can we discuss medical information or test results with family members?  
If yes, identify their names and relationship to you.  Yes  No

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_

## RESPONSIBLE PARTY (INSURED) INFORMATION

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex:  Male  Female  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Phone \_\_\_\_\_  
Employer \_\_\_\_\_

## REFERRAL SOURCE INFORMATION

Name of Personal Physician \_\_\_\_\_ Phone \_\_\_\_\_  
Whom may we thank for referring you to?  Dr \_\_\_\_\_  Friend \_\_\_\_\_  
 Other \_\_\_\_\_  Yellow Pages  Insurance Plan Booklet  
 Search Engine, please specify: \_\_\_\_\_

PAYMENT IN FULL IS EXPECTED AT THE TIME OF SERVICE UNLESS YOU ARE A MEDICARE PATIENT OR ARE IN A MANAGED CARE PLAN WITH WHICH WE PARTICIPATE. FOR THOSE PATIENTS, THE PAYMENT FOR ANY COPAYMENT, UNMET DEDUCTIBLE, AND/OR NON-COVERED SERVICES WILL BE COLLECTED AT THE TIME OF SERVICE.

- I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID FOR BY MY INSURANCE COMPANY. I UNDERSTAND THAT A MONTHLY 1.5% MONTHLY REBILLING FEE (\$5 MINIMUM) WILL BE APPLIED TO ANY OUTSTANDING PATIENT BALANCE.
- I UNDERSTAND THAT A \$25 FEE WILL BE CHARGED TO ME FOR ANY MISSED APPOINTMENT WITH THE PHYSICIAN, PHYSICIAN ASSISTANT OR AESTHETICIAN WHICH IS NOT CANCELLED WITHIN 24-HOURS OF THE SCHEDULED APPOINTMENT TIME.
- I UNDERSTAND THAT PAYMENT OF THIS CHARGE IS MY RESPONSIBILITY AND NOT THE RESPONSIBILITY OF MY INSURANCE COMPANY.

I ACKNOWLEDGE THAT I HAVE BEEN GIVEN THE OPPORTUNITY TO READ THE PRIVACY PRACTICES.

Patient or Responsible Party's Signature \_\_\_\_\_ Date \_\_\_\_\_