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 us? ☐ 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 WELL 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 _____