FAIRFIELD DERMATOLOGY

Patient Registration Form

PATIENT INFORMATION *Please Print Clearly*

Name_____ Social Security# _____
Last First M.I.

Address_____
City State Zip

Date of Birth ____/____/_____ Age_____ Sex_____ Marital Status_____

Race*(Req) _____ Ethnicity *(Req) :Hispanic/Non-Hispanic Employer_____

Check Preferred Phone Number

Home Phone _____ ☐ Work Phone_____ ☐ Cell_____ ☐

Referred by_____ Primary Care Physician_____

Email Address (required if applicable)_____

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name_____ Social Security# _____
Last First M.I.

Address_____
City State Zip

Date of Birth ____/____/_____ Age_____ Sex_____

INSURANCE INFORMATION PLEASE REMEMBER TO PRESENT YOUR INSURANCE CARD(S) AT TIME OF VISIT

Primary Insurance	Secondary Insurance
Name of Insured_____	Name of Insured_____
Date of Birth ____/____/_____	Date of Birth ____/____/_____

Cancellation Policy

Thank you for booking your appointment with us. As a courtesy we call our patients to confirm upcoming appointments. If an appointment needs to be rescheduled or cancelled, it is the patient's responsibility to notify the office with a minimum of 24hrs notice. ***If our office has not received notice to cancel or reschedule your appointment within the required 24hrs, you will be billed accordingly, per this financial agreement. Your health plan does not cover payment for missed appointments; therefore, you are responsible for this payment in full.*** Please help us better serve all of our patients by notifying us as soon as possible if you must change or reschedule your appointment.

Cancellation fees: Office Visit $25/Surgical excisions $50/Chemical peels, Microdermabrasion $50
Laser Procedure $100/Other Cosmetic appointments (fillers, sclerotherapy) $100/Fraxil CO2 laser $500 (requires 48hrs notice cancellation)

COPAYMENT IS EXPECTED AT TIME OF SERVICE

I understand that it is my responsibility to provide accurate and current demographic and financial information on the date of service. If I do not provide a copy of my insurance card on the date of service, I will be responsible for payment of medical services provided. I also understand that I am personally responsible for payment of medical services rendered should my insurance company deny payment for any reason. Your signature below indicates that you understand and accept all aforementioned policies included on this document. I hereby authorize payment of insurance benefits directly to the physician for medical services provided. I further authorize the release of medical information necessary to process any claim.

Patient or Responsible Party Signature_____ Date ____/____/_____