DERMATOLOGY AND AESTHETICS INC

29525 CANWOOD STREET, SUITE 219
AGOURA HILLS, CA 91301
818.865.8133

DATE: _____/_____/ _____

PLEASE PRINT

PATIENT NAME (last)_____(first)_____ (MI)___ SEX: M_____F____

ADDRESS (street)_____

(city)_____ (state) _____ (zip) _____

BIRTHDATE: _____/_____/_____ SOC. SEC. #: _____ CELLPHONE: (_____) _____

EMPLOYER: _____ HOME PHONE: (_____

OCCUPATION: _____ EMAIL: _____

INFORMATION: If insurance is not in your name, please fill out the card holder.

PATIENT NAME (last)_____(first)_____ (MI)___ SEX: M_____F____

ADDRESS (street)_____

(city)_____ (state) _____ (zip) _____

BIRTHDATE: _____/_____/_____ SOC. SEC. #: _____ CELLPHONE: (_____) _____ _____

EMPLOYER: _____ HOME PHONE: (_____

OCCUPATION: _____ EMAIL: _____

NEAREST RELATIVE NOT LIVING WITH YOU: _____ PHONE #:_____

EMERGENCY CONTACT NAME: _____ PHONE #: _____

PRIMARY PHYSICIAN NAME: _____ PHONE #:_____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____ PHONE #: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY: _____

SUBSCRIBER NO. _____RELATHONSHIP TO SUBSCRIBER: SELF____ SPOUSE_____ CHILD_____

SECONDARY INSURANCE COMPANY: _____

SUBSCRIBER NO. _____RELATHONSHIP TO SUBSCRIBER: SELF____ SPOUSE_____ CHILD_____

PLEASE READ THE FOLLOWING:

I authorize and consent to all medical treatment deemed necessary to treat the above patient. I directly assign all medical/surgical benefits to the office of Dermatology and Aesthetics, Inc. And Bente Berman, MD. I authorize this office to release all information necessary to secure payment of benefits. I understand medical treatment may not be covered by my insurance carrier and any remaining balance is therefore my responsibility, including balances due to lapse of or terminated coverage of insurance policies. It is the responsibility of the patient to know how their insurance plan operates, such as copays, deductibles and specific exclusions on your policy! **If treatment is considered cosmetic, it is my responsibility to pay for those procedures at the time of service.**

_____ _____

Signature of Patient or Responsible Party Date