REDWOOD EMPIRE DERMATOLOGY

6574 OAKMONT DRIVE, SUITE B, SANTA ROSA, CA 95409
301 EAST ST, HEALDSBURG, CA 95448

PATIENT INFORMATION ☐ Male ☐ Female

Name _____
First Middle Last

_____
Address: Street City State Zip Code

Home phone _(_____)_____ Cell phone __(_____)_____

May we leave medical information on your voice mail? ☐ Yes ☐ No Email: _____

Date of Birth _____/_____/_____ Your age today _____ Primary Care Physician _____

Who referred you to our office? _____ Last 4 digits of your SSN: ___ ___ ___ ___

RESPONSIBLE PARTY

Parent, Spouse, or Responsible Party (if different from patient) _____

Home phone _(_____)_____ Date of birth _____

_____
Address: Street City State Zip Code

INSURANCE INFORMATION

Primary Insurance _____ Secondary Insurance _____

Policy holder (if different from patient) _____ Relationship to patient ☐ self ☐ parent ☐ spouse

Policy holder's date of birth _____ Policy holder's SSN _____

_____
Address: Street City State Zip Code

EMERGENCY CONTACT INFORMATION:

Emergency Contact _____ Emergency Contact PH (_____)_____

DO YOU GIVE OUR OFFICE PERMISSION TO DISCUSS YOUR MEDICAL INFORMATION WITH FAMILY MEMBERS?

☐ Yes ☐ No If yes, please provide their names and phone numbers below.

Name _____ Relationship _____

Telephone (day) (_____)_____ Telephone (evening) (_____)_____

PLEASE NOTE OUR BILLING POLICY AND INDICATE YOUR ACCEPTANCE OF THESE TERMS BY SIGNING BELOW:

- If your check is not honored by your bank, you will be charged a **$25 fee** by our office.
- If you cannot keep your scheduled appointment, we request **24 hours cancellation notice**.
- We reserve the right to charge: **$50 fee** for missed office visits – and – **$100 fee** for missed surgical appointments.
- You are responsible for charges applied to your deductible, coinsurance and copay amounts, as well as for non-covered services and cosmetic services. Your copay is due on the date of service. If you have not met your annual deductible, you will be asked to pay 50% of today's charges. We will bill your insurance and refund any overpayment on your account in a timely manner.
- We will not bill your insurance for cosmetic services provided.
- We do not provide medical care for workers' compensation injuries or claims.
- You authorize payment of medical benefits to Redwood Empire Dermatology for services rendered.
- You agree that a photocopy of this agreement shall be as valid as the original.

We update paperwork annually. We appreciate your cooperation.

Patient or Responsible Party Signature _____ Date _____