derm sd
San Diego Dermatology & Laser Surgery 12395 El Camino Real, Ste. 207, San Diego CA 92130 858.350.5555 f:858.350.5139 www.dermsd.com

Patient name (Last, First, MI)	S M D W Marital Status
Date of Birth	Social Security number
Address	City, Zip code
Home phone	Cell phone
Employer Information	
Work phone	Email address

Please indicate the best number to contact you(circle one): HOME CELL WORK
May we leave a message? YES NO

Emergency contact and relationship	Phone number

Insurance carrier

Resposible party name and social security number(if different than patient)

Secondary insurance

Primary care doctor	Phone
Referring doctor	Phone

Allergies

AUTHORIZATIONS:

My signature on this form authorizes San Diego Dermatology & Laser Surgery to perform medical/ surgical diagnosis and treatment, anesthesia, diagnostic exam and specimen exam by pathology, in the care of the minor named herein_________________________________. I am legally responsible for this minor and therefore accept financial responsibility for the payment of services.
Signature of Parent/Legal guardian____Date:_________________

I authorize the release of medical information to my primary care or referring physician to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician. I understand that if my insurance does not pay in full, that I will be financially responsible for co-payments, co-insurance, deductibles and non-covered services. **We do not bill for cosmetic procedures.**
Signature of Patient/Legal guardian____Date:________________

If the physician needs a second opinion on any tissue removed for purposes of a skin biopsy during my exam(or minor's exam) in order to make a final diagnosis of any condition, I accept responsibility for the payment of specialist who makes the diagnosis. I understand that I will receive a separate billing from the specialist(Dermatopathologist)
Signature of Patient/Legal guardian____Date:________________

I understand that I will need to reserve my appointment for any cosmetic procedure over $100 with a credit card number upon scheduling. Furthermore, I understand I will be charged $100 for no show or missed appointments without notifying the office 48 working hours in advance. After the 3rd no show apoointment patients will be required to secure their next appointment with a non-refundable fee of $200.
Signature of Patient/Legal guardian____Date:_________________