



Dale Westrom, MD, PhD ♦ Susan Amaturro, MD ♦ Holly Christman, MD ♦ Ashley Smith, MD ♦ Christen Thompson, ARNP

PATIENT INFORMATION

Male Female

Name _____
First Middle Last

Address: Street City State Zip Code

Home phone (____) _____ Cell phone (____) _____

May we send you email reminders and information? 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) (____) _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES: My signature below indicates I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices).

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 return check 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, we request \$100 prepayment on your account at the time of service in addition to your copay.
- You authorize payment of medical benefits to Redwood Empire Dermatology, Inc 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 _____

- 990 Sonoma Ave., Ste.2, Santa Rosa
- 301 East St., Healdsburg