



BEACH CITIES DERMATOLOGY

520 NORTH PROSPECT AVENUE, SUITE 302 - REDONDO BEACH, CALIFORNIA 90277 (310) 798-1515
3831 HUGHES AVENUE, SUITE 504 - CULVER CITY, CALIFORNIA 90232 (310) 204 - DERM
927 DEEP VALLEY DRIVE, SUITE 165 - ROLLING HILLS ESTATES, CALIFORNIA 90274 (310) 265-5515
P.O. BOX 4384 - BIG BEAR LAKE, CALIFORNIA 92315 (909) 866 - 8688

PATIENT INFORMATION PLEASE PRINT

Patient's Name: _____ Date of Birth: _____ Age: _____

Street Address _____ City _____ State _____ Zip _____

Home Telephone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Male: _____ Female: _____ Ht: ___' ___" Wt.: _____ pounds Social Security Number: _____ - _____ - _____

Single: _____ Married: _____ Widowed: _____ Divorced: _____

Employer: _____ (F/T P/T unemployed) Work Phone: (____) _____ - _____

Address: _____
STREET CITY STATE ZIP

Drivers License #: _____

Occupation: _____ E-Mail Address: _____

REFERRAL INFORMATION

Who referred you to this office? _____

Have you seen another doctor for this problem? Yes No Name: _____

CO PAYS, DEDUCTIBLES AND COINSURANCE AMOUNTS ARE DUE AT THE TIME OF SERVICE. IF YOU HAVE QUESTIONS ABOUT YOUR COVERAGE PLEASE ASK BEFORE SERVICES ARE RENDERED. If your insurance coverage is not effective or does not cover certain services performed you are financially responsible for these services rendered. Some insurance plans have a separate deductible for any surgical procedures that are done in a doctor's office.

I understand the failure to make the required copayment / deductible at the time of service will result in a \$25 service charge to my account.

I have read the above and understand my financial responsibility for services rendered in this office.

I understand that any appointments not cancelled or rescheduled with at least 24 hours notice will incur a \$30 service charge to my account.

I understand that any account turned over for collection proceedings will incur a fee of \$25.00

SIGNATURE: _____ DATE: _____

GUARANTOR/INSURED INFORMATION

Name of insured: _____ Male/Female Relationship to patient: _____

Address: _____ Date of Birth: _____

SS#: _____

Employer: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Employer: _____

Address: _____ Address: _____

Telephone: (____) _____ - _____

Telephone: (____) _____ - _____

Social Security #: _____ - _____ - _____

Occupation: _____

Relationship: _____

May we call them at work? Yes No