

VACAVILLE DERMATOLOGY

Please fax to (707) 446-2775

Prior to your appointment

PATIENT REGISTRATION

Name _____ Nickname _____
Last First M.I.
Address _____
Street City State Zip
Home Phone _____ SSN _____
Work Phone _____ Gender Male Female
Cell Phone _____ Marital Status S M D W
Date of Birth _____ If child, parents' names _____
Occupation _____ Employer _____
Referred by _____ Primary care physician _____
Pharmacy of choice(name) _____ Pharmacy Location _____

INSURANCE INFORMATION *(Please present insurance cards to receptionist for copying)*

Primary Insurance Co _____ Secondary Insurance Co _____
Relationship to policyholder _____ Relationship to policyholder _____
Policy holders **Name and date of birth** _____

EMERGENCY CONTACT INFORMATION

Contact person in the event of an emergency _____
Name Phone Relationship

HOW DID YOU HEAR ABOUT US?

Physician _____ www.vacavillederm.com Vacaville Magazine
 Insurance _____ Yellow Pages Grapevine / Breeze / Roundup
 Family/Friend _____ Community Parent Other _____

AUTHORIZATIONS

I hereby consent to Medicare, MediGAP, and other Insurance companies to pay my benefits on my behalf directly to Vacaville Dermatology and Nandan V. Kamath, M.D. for any services provided. I understand that by signing below, I am authorizing all such care as well as collect appropriate payments. In addition, I understand that I am still responsible for any co-payments, co-insurances, and deductibles per my specific insurance policies. Not all services will be covered, including any cosmetic treatments, and I understand that I am fully responsible for such charges. I have read the above payment policy as well as general office policies (separate handout) of Vacaville Dermatology and hereby agree to the Policies.

Signature of Patient/Legal Guardian

Date