



PATIENT INFORMATION					
First Name		Middle Initial	Last Name		Today's Date
Date of Birth	Age	Marital Status	M <input type="checkbox"/> F <input type="checkbox"/>	Social Security Number	
Guardian Name (If Minor)			Relationship		
CONTACT INFORMATION					
Address			Email Address		
City			State	Zip	
Home Phone			Cell Phone		
Emergency Contact			Phone Number	Relationship	
EMPLOYER INFORMATION					
Employer Name			Occupation		
Address			Phone		
City			State	Zip	
INSURANCE INFORMATION					
Insurance Company Name			Policy Identification Number	Group Number	
Subscriber Name	Relationship		Social Security Number	Date of Birth	
Secondary Insurance	Subscriber Name		Policy Identification Number		
GUARANTOR INFORMATION					
Please complete the section below if <i>someone other than the patient</i> is responsible for the bill.					
Address			Phone		
City			State	Zip	
Home Phone			Relationship to Patient	Occupation	
Employer			Address	Phone	
City			State	Zip	

Your signature below indicates your consent for treatment and responsibility for any fees incurred. I hereby authorize the release of any information acquired in the course of my examination or treatment to my insurance company. I hereby authorize the payment of medical benefits directly to the physician.

Signature: _____ Date: _____

REFERRAL SOURCE	
How did you hear about us? Please check all that apply.	
<input type="checkbox"/> Physician Referral _____ <input type="checkbox"/> Family / Friend _____ <input type="checkbox"/> Internet Search _____ <input type="checkbox"/> Newspaper _____	<input type="checkbox"/> Hospital Website _____ <input type="checkbox"/> www.Dermedica.org _____ <input type="checkbox"/> Insurance _____ <input type="checkbox"/> Other _____

PATIENT NAME: _____

CONSENT TO TREATMENT

I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examinations and treatment.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, a collection fee, not to exceed 50% of the overdue balance may be added to the amount due. I am financially responsible for the added collection fee and any reasonable attorney fees, court costs and other costs incurred for collection.

24 HOUR CANCELLATION POLICY

*As a courtesy to other patients, we have established a 24 hour cancellation policy. All appointments must be cancelled 24 hours prior to the scheduled time. If an appointment is missed without proper notification, a **\$50.00 fee** will be charged to the patient. A **\$75.00 fee** will be assessed for laser, surgery or cosmetic appointments cancelled or missed without proper notice. These fees will not be covered by medical insurance.*

A federal law requires the presentation of photo identification prior to your appointment at our office.

I certify that I have read this form and understand its contents.

I certify that I have read and agree with the Notice of Privacy Practices (HIPPA).

Patient or Other legally authorized person

Date

Julie S. Goldberg, M.D., S.C.

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