

DIABLO DERMATOLOGY

3436 Hillcrest Ave., Suite 150, Antioch, CA 94531 ☐ (925) 754-6767
www.diablotdermatology.com

In order to serve you properly, we will need the following information. PLEASE PRINT. All information will be strictly confidential.

Patient Information

Today's Date ___/___/___

Name (LAST) (FIRST) (MI)

Mailing Address (NUMBER) (STREET) (CITY) (STATE) (ZIP CODE)

Email Address: Occupation:

Home #: () Cell #: () Work #: ()

How do you prefer to be contacted? Home Phone Cell Phone Email (Please check one)

Date of Birth ___/___/___ Age Sex Martial Status

If a Student: Full Time Part Time Name of School:

Nearest friend or relative not residing with you?

Relationship: Phone ()

PARENT OR RESPONSIBLE PARTY (If different from patient)

Name (LAST) (FIRST) (MI)

Mailing Address (NUMBER) (STREET) (CITY) (STATE) (ZIP CODE)

Home #: () Work #: () Cell #: ()

Date of Birth ___/___/___ Sex Relationship to the Patient

DO WE HAVE PERMSSION TO: (Please circle your answer)

Table with 4 columns: Question, YES, NO, NA. Rows include: Leave a message on your home answering machine?, Leave a message at your place of employment?, Leave a message on your cell phone?, Send an appointment reminder card to your home?, Send an Email or text message to confirm appointments?, Discuss your medical condition with any member of your home?

If yes, person's names and relationship to you:

ALL ACCOUNTS ARE DUE AND PAYABLE AT THE TIME OF THE VISIT UNLESS SPECIAL ARRANGEMENTS ARE MADE IN ADVANCE. WE ARE REQUIRED TO ABIDE BY THE CONTRACTURAL AGREEMENT MADE WITH THE INSURANCE COMPANIES.

I authorize this office to release any information necessary to expedite insurance claims. I assign to Dr. Noel Chiu direct payments of insurance benefits to which I am entitled for medical and/or surgical care. I understand that I am responsible for all charges, regardless of insurance coverage. I will inform Dr. Noel Chiu's office of any change insurance coverage. Any payment denied due to my failure to inform Dr. Noel Chiu's office of insurance changes or related errors in referral authorizations will be my financial responsibility.

I authorize Dr. Noel Chiu and/or Associates to give me appropriate medical care by today's standards. I acknowledge I shall be financially responsible for all elective-cosmetic procedures not covered by my insurance plan.

I hereby authorize Dr. Noel Chiu and/ or Associates to treat my son/daughter as necessary.

Patient, Parent, or Guardian Signature X Date ___/___/___