

Dulles Cosmetic Surgery and Skin Care Center

14 Pidgeon Hill Drive
Suite #100
Sterling, VA 20165
(703) 406-2444

David E. Berman, M.D.

PATIENT REGISTRATION

DO YOU HAVE A LIVING WILL? YES NO INITIALS

PATIENT NAME: FIRST		M.I.	LAST		MAIDEN NAME	SOCIAL SECURITY #		DATE OF BIRTH
					Sex M or F			
HOME ADDRESS			APT #	CITY	STATE	ZIP	HOME PHONE	
EMPLOYER		ADDRESS					WORK PHONE	
EMAIL			REFERRED BY: FIRST and LAST NAME			CELL PHONE		
ALLERGIES TO MEDICATION		PERSONAL PHYSICIAN: FIRST and LAST NAME (Give address and Phone if known)				MARITAL STATUS ___S ___M ___W ___D		
SPOUSES NAME				WORK PHONE:		OCCUPATION		
PERSON TO CONTACT IN CASE OF EMERGENCY (NOT RESIDING WITH YOU)							TELEPHONE	
POLICY HOLDER NAME		SOCIAL SECURITY NUMBER		DATE OF BIRTH		FINANCIALLY RESPONSIBLE PERSON ___PATIENT ___SPOUSE ___PARENT ___OTHER		
EMPLOYER		ADDRESS					WORK PHONE	
How did you hear about us?					Occupation			

Primary Insurance Billing Information

Secondary Insurance Billing Information

Ins. Co. Name _____ Address: _____ City, State & Zip: _____ ID.No: _____ Group Name: _____ Group # _____ Subscriber: _____ (Person's Name) Subscribers Date of Birth: _____ Subscriber's Social Security # _____	Ins.Co. Name _____ Address: _____ City, State & Zip: _____ ID.No: _____ Group Name: _____ Group# _____ Subscriber: _____ (Person's Name) Subscriber's Date of Birth: _____ Subscriber's Social Security # _____
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PAYMENT POLICY

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office. In the event my account is turned over to an attorney for collections, I will pay any fee/costs incurred during the collection process.

If an appointment is not canceled within 24hrs a \$100.00 fee is required.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Dulles Cosmetic Surgery and Skin Care Center to furnish information to insurance carriers (including Medicare/Medigap) concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurances.

Date

Signature of Subscriber or Beneficiary

I acknowledge that I have been offered a copy of the privacy notice of Dulles Cosmetic Surgery and Skin Care Center.

Copy Taken _____ Copy Declined _____

Date

Signature of Patient