PATIENT INFORMATION

Date: _____

Name (last, first, MI):_____

Sex: Male Female

Address: _____

City: _____ State_____ Zip_____

Home Phone #: (____) _____Cell: (____) _____Work #: (____) _____

Date of Birth: _____ Age: _____ SS# _____ Email: _____

What would you like us to call you? Do you have a nickname? _____

Where may we call you? HOME WORK CELL ANY

May we leave a message with a family member on a machine? YES NO

May we mail/email you information on services our office or our affiliates offer? YES NO

MARITAL STATUS (please circle): SINGLE MARRIED DIVORCED SEPARATED WIDOWED

SPOUSE (or parent if minor):

Name: _____ SS#:_____ Date of Birth_____

Home Phone#: (_____) _____ Work #: (_____) _____

YOUR EMPLOYMENT INFORMATION:

Occupation: _____ Employer: _____

Address: _____

City: _____ State_____ Zip_____

Phone #: (_____) _____

RESPONSIBLE PARTY'S NAME: _____ Phone # (_____) _____

EMERGENCY INFORMATION:

Name: _____ Relationship: _____

Address: _____ City & State: _____ Zip: _____

Phone #: (_____) _____

I hereby irrevocably assign and transfer all payment of benefits for the services rendered by Mark Mofid, M.D. and San Diego Skin, Inc. to be made directly to him regardless of my insurance benefits, if any, and agree to allow a photocopy of my signature to be used to file insurance. I understand that each patient (or responsible party) is financially responsible for services rendered. In the instance of dispute with my insurance company regarding payment, I authorize Mark Mofid, MD to act on my behalf. While the business office is pleased to assist in the preparation and submission of insurance forms, the obligation for payment remains that of the responsible party. In the case of an accepted Worker's Compensation injury, it is understood that the patient is not financially responsible. I also authorize Mark Mofid, MD to render medical treatment.

I understand that Dr. Mofid and San Diego Skin, Inc. may not be contracted with my insurance and a deposit may be required prior to services being rendered. I understand that this pre-payment is a deposit only and does not necessarily constitute payment in full. I will contact Dr. Mofid's business office within 10 days of receiving payment or other correspondence from my insurance company to settle my balance.

Mark Mofid, MD provides "before and after" photographs of patients as a representation of the overall types of medical services offered. These photographs are not intended to display results of what an individual patient may expect from a procedure. Results of procedures vary from one patient to the next and a physician cannot guarantee the success of a procedure or the given outcome. In the event that computer modeling is used to show a prospective patient a possible outcome, computer modeling is not a guarantee of a certain result or outcome. Computer modeling is not exact and real life results may differ from those shown by a computer model. I have read and understood the above information. _____ Initials

_____ _____ _____

Patient Signature Responsible Party's Signature Date