HEIGHTS DERMATOLOGY
& AESTHETICS
4325 Dolly Ridge Road, Birmingham, AL 35243 (205)591-2169

PATIENT INFORMATION ***(Please Print)*** **TODAY'S DATE**___/____/____

Name_____Date of Birth____/____/____
Last First MI

Mailing Adrdress_____
City State Zip Code

Home Phone_____Cell Phone_____Work Phone_____

SS#_____Sex_____Age_____Marital Status (Please Circle) S M D W

Employer_____Occupation_____

Email Address_____Pharmacy Name/ Phone #_____

Spouse/Parent's Name_____Date of Birth_____/_____/_____

SS#_____Employer_____Occupation_____

Home Phone_____Cell Phone_____Work Phone_____

In Case of Emergency, who should be notified?_____Phone_____

INSURANCE INFORMATION ***(Please present insurance card at time of check in)***

Primary **Insurance Name**_____	Secondary **Insurance Name**_____
Claim Address_____	**Claim Address**_____
Subscriber Name_____	**Subscriber Name**_____
Contract or ID #_____	**Contract or ID #**_____
Group #_____	**Group #**_____
Insured's Date of Birth_____/_____/_____	**Insured's Date of Birth**_____/_____/_____
Insured's SS#_____	**Insured's SS#**_____
Relationship of patient to insured_____	**Relationship of patient to insured**_____

Referred By_____ **Primary Care Physician**_____

I HAVE RECEIVED/BEEN OFFERED A COPY OF MONTCLAIR DERMATOLOGY'S HIPAA PRIVACY POLICY.

I authorize the release of my medical information to my primary care, referring physician, consultants, labs, pathology, or chart auditors if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits directly to Montclair Dermatology. I understand that payment for copays, coinsurances, deductibles or non-covered services is due at the time of service and that I am responsible for the charges incurred. I understand that failure to pay my copay at the time of service will result in a finance charge of $25.00 being added to my account. In the event that my account is turned over to collections, a 35% collection fee and any attorney fees will be added to my account. A fee of $38 will be assessed to any returned check. All surgical and cosmetic procedure cancellations within 48 hours and "NO SHOW" appointments will be charged a $100 missed appointment fee. All General Dermatology and Esthetician services cancellations within 48 hours and "NO SHOW" appointments will be charged a $50 missed appointment fee. Two "NO SHOW" appointments may result in discharge from practice.

Patient or Responsible Party Signature_____Date_____/_____/_____