Presidio Dermatology, Inc.
REGISTRATION FORM

PATIENT INFORMATION						
Patient's Last Name:	First:	Middle:				
Is this your legal name?		If not, what is your legal name?	(Former / Maiden Name):	Sex:	Age:	Birth Date:
❑ Yes	❑ No			❑ F ❑ M		/ /

Street address: Apt:	Social Security # (Optional)	Phone Number to confirm appointments:	
P.O. Box:	City:	State:	ZIP Code:

Email Address:	Primary Care Physician:

FOR CHILDREN:			
Parent's name:	Relationship to Child:	Home Phone:	Cell Phone:
Parent's name:	Relationship to Child:	Home Phone:	Cell Phone:

Cancellation Policy

Our office has a 24-hour cancellation policy. Patients will be charged a $50 fee for no-shows or same day cancellations.

X Patient Signature/Responsible party: ______________________________Date: _________________

Pathology Billing Notice

Please note: Pathology specimens will be sent to either UCSF, American Specialty Laboratory, or we will read the slides in house. Therefore if biopsies are performed, you may receive a separate bill. Almost all removals are sent for pathology. We request that if you have any questions or concerns about pathology prices that you contact your insurance carrier directly.

Please review this information and sign below to acknowledge receipt of this notice.

X Patient Signature/Responsible party: ____________________________Date: ___________________

Would you like to be added to our Newsletter email list? Yes/No

The newsletter includes new procedures, product information, sales, and updates within the office.