Michelle Aszterbaum, MD
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New Patient Form

Name:___________________________________ Date:________________

Address:____ Zip__________________

Date of Birth:__________________ Sex:____________ SSN:_________________

Home Phone:__________________ Cell Phone: __________________

☐ Please mark if okay to leave detailed voice message Email:_________________________________

Emergency Contact Name, Relationship to self:____

Phone: __________________

Referred by:____

Reason for Consultation

Dermatology (acne, skin check, Mohs surgery, rash, skin care, etc). Please list any areas of concern:

____

Cosmetic (laser, fillers, infini, CO2, etc). Please list areas you are interested in learning about:

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Our Financial Policy For All Patients

Payments must be rendered at the time of service. If we are in network with your plan we will bill your insurance, but you are responsible for all co-payments and deductibles. The patients is responsible for any charges not paid by the insurance company. It is your responsibility to verify whether or not our provider is participating with your insurance plan. Please discuss any fees prior to your examination. In the event we are not contracted with your insurance plan, we will provide you with an itemized statement for you to send for reimbursement. I give Michelle Aszterbaum, MD permission to treat the above named patient. I understand I am financially responsible for all changed incurred and balance not paid directly by the insurance company.

Signature:____ Date:_____________________