D. Dennis Faludi, M.D.

Patient Registration Form

Name: ____ Today's Date: ___________________________________

Address: ____ Occupation: ____________________________________

City, State, Zip: ____________________________________ Employer: _______________________________________

Email Address: ____________________________________ Emergency Contact: ______________________________

Home Phone: ______________________________________ Phone #: _______________________________________

Mobile Phone: _____________________________________ Relationship to Patient: ___________________________

Work Phone: ______________________________________ Dermatologist: __________________________________

Date of Birth: _____________________________________ Phone #: _______________________________________

Sex: M _______ F _______ Preferred Pharmacy: _____________________________

Marital Status: ____________________________________ Phone #: _______________________________________

How did you hear about Aesthetic Medical Center? ____

Please circle YES or NO below to indicate whether we have permission to:

Leave a voicemail message at home	YES	NO
Leave a message at your place of employment	YES	NO
Send email messages regarding your treatment	YES	NO

PAYMENT AND CANCELLATION POLICIES

Payment is expected from you in full at the time of service for all treatments. For your convenience, we accept cash, personal checks, Visa, MasterCard, American Express, and Discover. We request 24 hours notice for cancellation of any appointment. Failure to provide at least 24 hours cancellation notice may result in an advance deposit being required from you for future appointments. Your signature below indicates that you understand and accept these policies.

____ ___________________________________

Signature of Patient or Legal Guardian Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

You understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), you have certain rights to privacy regarding your protected health information. A copy of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of your health information is available upon request. You understand that Aesthetic Medical Center has the right to change its Notice of Privacy Practices from time to time and that you may contact this organization at any time to obtain a current copy of its Notice of Privacy Practices.

____ ___________________________________

Signature of Patient or Legal Guardian Date