Hala Koudsi, M.D., Inc
Dermatology & Skin Cosmetic Surgery

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New Patient Information

Name:

Street Address:

City: State: Zip Code:

Home Phone: Work: Cell:

Date of Birth: Age: Sex: SS#

Referred by:

E-mail Address:

Would you like us to send a letter to your referring doctor: ☐ Yes ☐ No

Parent /Guardian / Spouse / Subscriber Information

Name:

Street Address:

City: State: Zip Code:

Home Phone: Work: Cell:

Date of Birth: Age: Sex: SS#

Next of Kin:

Street Address:

City: State: Zip Code:

Employer:

Insurance Co. HMO ☐ PPO ☐ Medicare ☐ Other

* Credit Information is required for check acceptance & special billing arrangements*

Drivers License# State of Issue:

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies for our office. Payment is required for all services at the time they are rendered. We accept payment in the form of cash, check or credit card. In the event of hospitalization or major procedures, our office will file with the appropriate insurance. However, before such claims are filed, coverage will be verified and you will be asked to pay any deductibles, non-covered services and copymnets. Your signature below signifies your understanding and willingness to comply with the policy.

Patient Signature Date