Westford Dermatology & Cosmetic Center
506 Groton Road
Westford, MA 01886

Name ____

Home address ____
Street City State Zip Code

Email address________________________________

*Date of birth________________________________

Primary Phone #______________________________

Secondary# ______________________________________

Emergency Contact: __________________ (Relation to patient) ____________________________ Phone: _______________________

*Primary care physician name_________________________ Address______________________________________

Insurance Company ____________________

Subscriber Name: ___________________ Subscriber DOB: ___________ Relationship ___________

Parent or Responsible Party Information (if different from patient)

Name____
Last First Middle

Address____
No. Street City State

Home Phone #__________________________ Cell Phone#______________________________

Is it ok to leave results on an answering machine? __________ If Yes, Whom may we discuss results with? ______________________________

I hereby authorize and assign my insurance benefits to be paid directly to Westford Dermatology & Cosmetic Center. I authorize release of information to process insurance. I give Westford Dermatology & Cosmetic Center permission to treat me and take photographs. Payment is required for all services at the time they are rendered. Co-payments and deductible are collected at the time of the office visit. I have received and understand WDCC financial policies and notices of Privacy Practices. Your signature below signifies your understanding and willingness to comply with these policies.

Waiver: I understand if I am required to obtain a referral from my Primary Care Doctor prior to seeing a specialist. My insurance carrier determines when a referral is necessary. If I do not have a referral at the time of service or unable to obtain a referral I am financially responsible for all services. _____________

Patient or Responsible Party Signature____Date__________________________