SATO GENERAL & COSMETIC DERMATOLOGY, LLC

Patient Information as of _____ (enter today's date)

(Please Print Legibly & Fill In All Fields)

PATIENT'S NAME _____ Date of Birth ____/____/____

First Middle Last

Address _____

Street & Apt # City State ZIP

Home Phone _____ Cell Phone _____ Preferred way to contact _____

E-mail: _____ Is it ok to leave voice or email messages? ◯ Yes ◯ No

Ethnicity _____ Language _____ Sex: ◯ Male ◯ Female

Marital Status ◯ Single ◯ Marrried to: _____ ◯ Other: _____

EMERGENCY CONTACT _____ Relationship to Paitent _____

Home Phone _____ Cell Phone _____

PATIENT'S EMPLOYER _____ Occupation _____

PRIMARY CARE PHYSICIAN _____ Office Location _____

How did you hear about us? : _____

PREFERRED PHARMACY _____ Location _____

PRIMARY HEALTH INSURANCE COMPANY _____

Subscriber Name (if other than self) _____ DOB _____

SECONDARY HEALTH INSURANCE COMPANY _____

Subscriber Name (if other than self) _____ DOB _____

I give permission for Sato General & Cosmetic Dermatology, LLC to provide medical treatment for myself. I understand I have the right to discuss all medical treatments with Dr. Ryan Sato and I have the right to refuse any procedure or treatment.
I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Sato to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. If I do not show up to my scheduled appointment I recognize that I will be responsible for a $25 fee. I understand that my contract is between Dr. Sato and myself.

Signature _____