Patient Information Record
(Please print legibly and please answer **ALL QUESTIONS**)

Thank you for choosing Davis Dermatology.
We are glad you are here and look forward to a long lasting relationship.

Patient Name: ___________________________________ Date of Birth: _______________________________

Social Security # (required): _________________________ Email Address: ______________________________

Would you like to receive periodic clinical /medical newsletters and special offers from Dr. Davis: Yes No

Home Phone: ___________________ Cell Phone: ____________________ Temp phone: _____________________

Please place a check next to the phone number you would like to be contacted on.

Permanent Address: __________________________ City: __________________________ State: ____ Zip Code: ________

Temporary Address: __________________________ City: __________________________ State: ____ Zip Code: ________

Occupation: _______________________________ Work Phone: ____________________ Check if retired: _____

If patient is under 18 yrs. of age please complete the following section

Guardian Name: __________________________________ Phone Number: ________________________________

Address: ______________________________________ City: __________________ State: _____ Zip Code: __________

Primary Insurance Carrier ______________________________ ID # ____________________ Group # _____________

Policy Holder's Name____ Relationship_____________________

Secondary Insurance Carrier _______________________________ ID # __________________ Group # _____________

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PLEASE COMPLETE THE OTHER SIDE

Cancellation and No Show Fee Policy

Your appointment time is reserved especially for you and each time a patient misses an appointment without providing appropriate notice, another patient is prevented from receiving care. Please contact our office at 386-423-2218 no less than **24 hours prior to your scheduled office visit appointment time and 48 hours prior to a scheduled procedure/surgery appointment if you are unable to keep your appointment.**

If you check in for your appointment more than 15 minutes past your scheduled appointment time, you may need to be rescheduled to the next available appointment time and date and the above no show policy will be enforced.

Davis Dermatology P.A. reserves the right to charge a $25.00 fee for all missed (Late Cancellation/No Show) office visit appointments and a $75.00 fee for all missed (Late Cancellation/No Show) procedure /surgery appointments.

These fees are not covered by your insurance carrier and must be paid prior to your next appointment. Multiple “no shows” or same-day cancellations in a six month period may result in termination from our practice.

We appreciate your understanding and cooperation as we strive to best serve the needs of all our valued patients.

By signing below, you acknowledge that you have received this notice and understand our practice's policy.

Signature of patient or legal guardian ______________________________

Printed Name ________________________________

Relationship to Patient (if other than the Patient is signing)________________________

Date ____________________