ROMERO CLINIC
WILLIAM H. E. ROMERO, MD

103 Majestic Drive
Dix Hills, NY 11746-4933
631-858-0500

PATIENT INFORMATION

PLEASE PRINT CLEARLY

LAST NAME	FIRST NAME	
HOME STREET ADDRESS		
CITY, STATE, ZIP CODE		
WORK STREET ADDRESS		
CITY, STATE, ZIP CODE		
HOME PHONE		
MOBILE PHONE		
WORK PHONE		
E-MAIL ADDRESS		
DATE OF BIRTH	YOUR AGE:	
OCCUPATION	MARITAL STATUS:	
HOW DID YOU HEAR ABOUT US?		
EMERGENCY CONTACT PERSON		
EMERGENCY CONTACT NUMBER		

WHICH TREATMENT ARE YOU HERE FOR TODAY?

PLEASE ALSO CHECK FUTURE INTERESTS

☐ Botox	☐ ViPeel Chemical Peel
☐ Radiesse Filler	☐ Laser Resurfacing
☐ Juvederm Filler	☐ Dermapen Resurfacing
☐ Juvederm Voluma Filler	☐ Eyelash Extensions
☐ Belotero Filler	☐ Oxygen Rx Treatment
☐ Liquid Facelift	☐ Skincare Consultation
☐	☐

CANCELLATION POLICY

Our office works hard to make our services available to as many patients as possible. Because of this dedication, we require that you inform us 2 business days in advance of any changes in your scheduled appointment. If you do not show up for your appointment, we shall charge you the regular consultation fee for that visit. If you inform us within 24 hours of your visit, we will charge you one-half of the regular fees. You may cancel your appointment within 2 business days (we are closed Sundays and Mondays) without incurring any penalty.

RETURNED CHECK AND COLLECTION AGENCY POLICY

Any returned check will be charged a $35 processing fee, plus any other bank fees incurred. Should we require the services of a collection agency to collect the monies owed us, you agree to pay for collection agency fee and other expenses incurred in full. By my signature, I acknowledge full understanding and agreement to the CANCELLATION, RETURNED CHECKS and COLLECTION AGENCY POLICIES.

CREDIT CARD INQUIRIES

In the event your credit card company requests or Dr Romero needs to submit copies of your medical records to explain a charge, your signature below authorizes the release of your medical records.

Signature: _____ Date: _____/_____/2015