

**Julie Anne Winfield, MD**  
Adult, Pediatric, and Cosmetic Dermatology  
770 Tamalpais Drive, Suite 402  
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**PATIENT REGISTRATION**

Patient Name: \_\_\_\_\_  
Last First Middle

Name You Wish To Be Called: \_\_\_\_\_ Gender: M F Marital Status S M W D

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell Phone: (\_\_\_\_) \_ \_\_\_\_

Do we have your permission to leave a detailed message at any of these numbers: Y N

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Email Address: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Employer: \_\_\_\_\_ Position \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_  
Relationship to Patient: \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

**Please be aware that we are not a contracting provider with any insurance and are not a Medicare provider. Payment in full is expected at the time of service.**

I, \_\_\_\_\_ hereby acknowledge my personal and financial responsibility to the office of Dr. Julie Anne Winfield for any and/or all services rendered to me. **I understand that I am financially responsible for all charges** whether or not paid by insurance. I have been made aware that Dr. Julie Anne Winfield is NOT a participating provider for any insurance company, and I am responsible for any communication with my insurance company for reimbursement for services. I am also aware that Dr. Julie Anne Winfield is not affiliated with Medicare and I waive my right to seek reimbursement for services under Medicare guidelines. I understand there is a 24-hour cancellation policy for all office visits. **I am aware and understand that if less than 24 hours of notice is given, I may be billed a fee of \$100 for a missed appointment.**

\_\_\_\_\_  
Patient/Guardian Signature Date / \_\_\_\_ / \_\_\_\_