Aesthetic Dermatology of Fairfield County
Sharon J. Littzi, M.D.
Diplomate, American Academy of Dermatology
Dermatology and Cosmetic Dermatology

PATIENT INFORMATION

First Name_____ **Last Name**_____ M.I. ____

Street Name _____Apt #_____

City_____ State_____ Zip Code_____

Home Phone (_____)_____-_____ Work Phone (_____)_____-_____ Ext. ____

Social Security No. _____-____-_____ Sex ____

Marital Status (Circle One) S M W D Date of Birth ___/___/_____

Employer _____Work Address _____

City _____State_____ Zip Code_____

Emergency Contact _____ Phone No._____

Email Address _____@_____

As of January 2009, we will need a credit card number to be on file with us because of patient deductibles, balance from insurance payments, co-pay's, insurance cancellations or an other charges not covered or paid at the time of service.

Your signature below authorizes us to charge your credit card for any balance due as a result of services rendered in our office. A receipt and bill be submitted to you each time any charges are applied. All credit card information will be kept confidential and no other party outside our office will have access to this information.

With your signature below you are authorizing Sharon J.Littzi, M.D.'s office to charge your credit card if you do not cancel your appointment within 48 hours of your scheduled appointment. Many thanks for your cooperation.

Credit card Number: Visa/MC _____-_____-_____-_____
Expiration Date_____/_____

_____ _____
Signature **Date**