Advanced Dermatology Skin Cancer and Laser Surgery Center, P.C.

(Please Print)

PATIENT NAME: (This section refers to PATIENT ONLY) **Patient Number :** ______________________

Name ____
Last First M.I. Nickname

Address ____ City __________ State _____ Zip _________

Home Phone ( ) ________________ Work Phone ( ) ________________ Cell Phone ( ) ________________

Date of Birth ____________________ Age ______ Sex _____ Social Security # ______________________________

Is the Patient? (Circle One) Single Married Separated Divorced Widowed E-Mail ________________________

Spouse's Name _________________________ Employer ___________________ Work Phone ( ) ________________

Race: (Circle One) White Black or African-American Native Hawaiian/Other Pacific Islander Asian Decline Other: __________

Preferred Language: (Circle One) English Spanish Other: ____________________

Ethnicity: (Circle One) Hispanic or Latino Not Hispanic or Latino Decline

RESPONSIBLE PARTY: (Person responsible for balance not covered by insurance, if different from patient)

Name ____________________________________ Relationship ____________________ Date of Birth ____________

Home/Cell Phone ( ) ________________ Work Phone ( ) ________________ Social Security # ______________

INSURANCE INFORMATION: Employer ____

Primary Insurance Company ___________________________________ Name of Insured ___________________________

EMERGENCY CONTACT INFORMATION:

In case of emergency, who should be notified? ____________________________________ Relationship ________________

Phone ( ) ________________ Work Phone ( ) ________________ Cell Phone ( ) ____________________

REFERRAL INFORMATION: (Please check the appropriate box below to help us determine how you were referred to our office.)

☐ Physician ☐ Friend ☐ Relative ☐ One of our Patients Name ______________________________________
First Name Last Name

☐ Dex Online ☐ Yellow Pages ☐ Referral Service ☐ Insurance ☐ Advaderm Website ☐ Newspaper ☐ Other

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I hereby acknowledge that I received Advanced Dermatology's Notice of Privacy Practices and have been given the opportunity to receive a printed copy to take with me if I choose to do so.

Patient or Responsible Party Signature ____ Date ____________________

PAYMENT POLICY:

I the undersigned give authorization to release any medical information necessary to process this and any future claims, and authorize payment of medical benefits for all physician services or supplies to be made to Advanced Dermatology Skin Cancer & Laser Surgery Center, P.C. I agree to be responsible for any self-pay (non-insurance balance), deductible, co-insurance, co-pay, no show appointments ($25 fee), or any other balance not paid by my insurance. Insurance is a **form** of payment and I realize I am ultimately responsible for any outstanding balance owed to Advanced Dermatology.

Patient or Responsible Party Signature ____ Date ____________________