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 # _____ Employer _____

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 _____ Relation _____ Date of Birth _____

Home/Cell Phone ( ) _____ Work Phone ( ) _____ Social Security # _____

CONTACT INFORMATION:

In case of emergency, who should be notified? _____ Relationship: _____

Home Phone ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____

Do you give permission for Advanced Dermatology staff to discuss your medical information with family members, including but not limited to : biopsy results, blood/ lab results, or other test results? **Yes** **No** If yes, please provide their names and numbers below.

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Do you give permission for Advanced Dermatology staff to leave detailed messages at your preferred contact number regarding any tests that you may incur as a patient, including but not limited to : biopsy results, blood/lab results, or other test results? **Yes** **No**

Preferred Contact Method: Home _____ Cell _____ Work _____

REFERRAL INFORMATION: (Please help us determine how you were referred to our office.)

Referring Physician: _____ Phone # _____

Primary Care Physician: _____ Phone # _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES and PAYMENT POLICY:

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. _____ Initial

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, or any other balance not paid by my insurance.

Patient or Responsible Party Signature _____ Date _____