

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

(Please Print)

PATIENT NAME: (This section refers to PATIENT ONLY)			Patient Number :		
Name	First		Miles		
		City _	M.I. Nickname State Zip		
Home Phone ()	Work Phone ()		Cell Phone ()		
Date of Birth Age	Sex Social	Security #	Employer		
Is the Patient? (Circle one) Single Married	Separated Di	vorced	Widowed E-Mail		
Spouse's Name	Employer		Work Phone ()		
Race: (Circle One) White Black or African-Ar	merican Native Haw	aiian/Othe	er Pacific Islander Asian Decline Other:		
Preferred Language: (Circle One) English	Spanish Other				
Ethnicity: (Circle One) Hispanic or Latino No.	ot Hispanic or Latino	Decline			
DECDONCIDI E DADTV. (Darana rangonalible	fan halanaa nat aassan	سيمينا المما	if different from mations)		
RESPONSIBLE PARTY: (Person responsible Name		-	Date of Birth		
			Social Security #		
CONTACT INFORMATION:					
In case of emergency, who should be notified?			Relationship:		
			Cell Phone ()		
Do you give permission for Advanced Dermato to : biopsy results, blood/ lab results, or other to	•		al information with family members, including but not limited If yes, please provide their names and numbers below.		
Name	Relationship _		Phone #		
Name	Relationship _		Phone #		
that you may incur as a patient, including but no	ot limited to : biopsy r	esults, blo	sages at your preferred contact number regarding any tests od/lab results, or other test results? Yes No Work		
REFERRAL INFORMATION: (Please help us d	etermine how you we	re referred	to our office.)		
Referring Physician:			Phone #		
Primary Care Physician:			Phone #		
RECEIPT OF NOTICE OF PRIVACY PRACTIC	CES and PAYMENT	POLICY:			
I hereby acknowledge that I received Advanced a printed copy to take with me if I choose to do			cy Practices and have been given the opportunity to receive		
payment of medical benefits for all physician	services or supplies	to be mad	essary to process this and any future claims and authorize de to Advanced Dermatology Skin Cancer & Laser Surgery e), deductible, co-insurance, co-pay, or any other balance not		
Patient or Responsible Party Signature			Date		