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.)

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 understand that responsibility for payment of medical services in this office for myself and my dependents is mine; due and payable at the time of services are rendered unless financial arrangements have been made. I understand that I am responsible for all costs of collection including attorney fees, collection fees of 30% and court costs. Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance. I also assign all benefits to Provider. I authorize the submission of claims without obtaining my signature on each claim submitted. I give my authorization and consent for treatment after having a full explanation of proposed treatment, alternatives, and risks by my doctor. I have been advised of my privacy rights as provided by the Healthcare Information Portability and Accountability Act of 1996. I hereby authorize Advanced Dermatology and its employees, agents, and assignees to contact me via e-mail, text messaging and to my cellular devices using automated telephone dialing systems.

Patient or Responsible Party Signature _____ **Date** _____