ADVANCED DERMATOLOGY & SKIN SURGERY, P.A.

PATIENT INFORMATION *(Please Print)* **Today's Date** ____/____/____

Name ____
Last First M.I.

Mailing Address ____ ______________
City State Zip (9 digits)

Home Phone__________________Work Phone__________________ SS# __________________
Area Code Area Code

Date of Birth ____/____/____ Age_____Sex_____ Marital Status _____Email______________________

PARENT OR RESPONSIBLE PARTY ***(if different from patient)***

Name ____
Last First M.I.

Address____
City State Zip

Home Phone __________________Work Phone__________________ SS#__________________
Area Code Area Code

Date of Birth____/____/____ Sex__________

INSURANCE INFORMATION ***(Please present insurance card at time of check in.)***

Primary Insurance Name __________________________
Ins. Address __________________________
Name of Insured __________________________
Insured's ID#__________________________
Insured's SSN __________________________
Group # __________________________
Insured's Date of Birth __________________________
Employer Name __________________________
Employer Address __________________________
Employer Phone __________________________
Area Code
Relationship of patient to the Insured ______________

Secondary Insurance Name__________________________
Ins. Address __________________________
Name of Insured __________________________
Insured's ID# __________________________
Insured's SSN __________________________
Group __________________________
Insured's Date of Birth __________________________
Employer Name __________________________
Employer Address __________________________
Employer Phone __________________________
Area Code
Relationship of patient to the Insured ______________

Pharmacy of choice ____ Phone __________________

Referred by: ____

Primary Care Physician ____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature ______________________________________ Date ____/____/____

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff are trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office will file with the appropriate insurance. However, before such claims are filed, coverage will be verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. In the event that your account must be turned over to collections, a $10.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature ______________________________________ Date ____/____/____

Advanced Dermatology & Skin Surgery

Patient Information Annual Updates and Signatures

If you are a new patient do not complete this page.

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

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Patient Information Updated By: ____________________(Employee Initials)

_____________________________________ Date ____/____/____
Patient or Responsible Party Signature

Patient Information Updated By: ____________________(Employee Initials)

_____________________________________ Date ____/____/____
Patient or Responsible Party Signature

Patient Information Updated By: ____________________(Employee Initials)

_____________________________________ Date ____/____/____
Patient or Responsible Party Signature

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Patient or Responsible Party Signature

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_____________________________________ Date ____/____/____
Patient or Responsible Party Signature

Updated By: ____________________(Employee Initials)

Patient or Responsible Party Signature _____________________________________ Date ____/____/____