

Skin Cancer Specialists, P.C.

PATIENT INFO **Preferred name to be called: _____ Today's Date: _____

Last Name: _____ First _____ M.I.: _____ Social Security#: _____

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: M F Marital Status: S M Occupation: _____

Employer: _____ Spouse Occupation: _____ Spouse Employer: _____

Home#: _____ Work#: _____ Cell#: _____

Pharmacy Name: _____ Phone #: _____ Location: _____

HOW DID YOU HEAR ABOUT US? Friend (Name: _____) Insurance/ Internet / Newspaper/ Other _____

Referring Dr: _____ Ph#: _____ Primary Dr: _____

RESPONSIBLE PARTY (THE PATIENT is the Responsible Party if OVER 18 years of age)

Last Name (if different than above): _____ First: _____ M.I.: _____

Address (if different than above): _____ Apt #: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

*PRIMARY INS. _____ Address: _____

Policyholder's Last Name: _____ First: _____ SS# _____

Date of Birth: _____ Sex: M F Policy I.D.# _____ Group#: _____

Relationship to Policyholder: Self Spouse Son Daughter *Deductible: _____ Copay: _____

*SECONDARY INS. _____ Address: _____

Policyholder's Last Name: _____ First: _____ SS# _____

Date of Birth: _____ Sex: M F Policy I.D.# _____ Group#: _____

Relationship to Policyholder: Self Spouse Son Daughter *Deductible: _____ Copay: _____

**EMERGENCY CONTACT: _____ RELATION: _____ PH#: _____

*Allergies to Medications: _____ Current Medications: _____

PRIVACY PRACTICES NOTICE AND WRITTEN ACKNOWLEDGEMENT FORM

I have been offered a copy of the Skin Cancer Specialists, P.C. Notice of Privacy Practices.

Signature of Patient/Guardian: _____ *Date:* _____

Permission is given to leave medical information in the specified manner and to the specified person(s) listed below.

_____ You may leave messages on my home answering machine

_____ You may call my work number

_____ You may leave messages on my work voicemail

_____ You may leave messages on my cell phone voicemail

_____ You may share information to no one but myself

_____ You may share medical and account information with my spouse _____
[NAME]

_____ You may share medical and account information with my children _____
[NAME(S)]

_____ You may share medical and account information with _____
[NAME]

AUTHORIZATION OF PAYMENT AND RELEASE OF INFORMATION

I request payment of authorized insurance benefits be paid to Skin Cancer Specialists, P.C. and authorize release of medical information to determine payable benefits for services rendered.

Signature of Patient/Guardian: _____ *Date:* _____