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 / 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:____________