

# Advanced Dermatology & Dermatologic Surgery, P.C.

HYUN-SOO LEE, M.D., F.A.A.D.

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日期 Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ 工卡號碼 Soc. Sec. #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

名字 : \_\_\_\_\_

Name Last (姓) First (名) M.I.

地址 : \_\_\_\_\_ Apt. #(公寓號碼): \_\_\_\_\_

Street Address (街道地址)

City (城市): \_\_\_\_\_ State(州): \_\_\_\_\_ (郵政編碼)Zip: \_\_\_\_\_

年齡: \_\_\_\_ 出生日期: \_\_\_\_月 \_\_\_\_日 \_\_\_\_年 婚姻狀況:  單身  已婚  其他 性別:  男  女  
 Age Date of Birth: MM DD YY Marital Status: Single Married Other Sex: Male Female

電話號碼: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ 手提號碼: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
 Home Phone Cellular Phone

緊急聯繫名字: \_\_\_\_\_ 緊急聯繫電話號碼: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
 Emergency Contact Emergency Phone

介紹醫生: \_\_\_\_\_ 電話: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
 Referring Doctor Phone

病人雇主: \_\_\_\_\_ 工作電話: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
 Patient Employer Work Phone

雇主地址: \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
 Employer Address

電郵地址(Email Address): \_\_\_\_\_ @ \_\_\_\_\_

Preferred Language:  English  Español  한국어  國語  廣東語  日本語  Other: \_\_\_\_\_

**PLEASE PRESENT TO THE RECEPTIONIST WITH ALL INSURANCE CARDS WHEN RETURNING THIS FORM.**

## 主要保險 Primary Insurance

你的保險需要專科看專科嗎?  Yes (是)  No(不是)  
 Does your insurance require a referral to see the specialist?

保險公司: \_\_\_\_\_ 保險號碼: \_\_\_\_\_  
 Insurance Carrier Insurance ID #

保單持有人: \_\_\_\_\_  
 Subscriber's Name Last (姓) First (名) M.I.

持有人出生日期: \_\_\_\_月 \_\_\_\_日 \_\_\_\_年 與病人關係: \_\_\_\_\_  
 Subscriber's DOB MM DD YY Relationship to Patient

## 第二保險 Secondary Insurance (If Applicable)

保險公司: \_\_\_\_\_ 保險號碼: \_\_\_\_\_  
 Insurance Carrier Insurance ID #

保單持有人: \_\_\_\_\_  
 Subscriber's Name Last (姓) First (名) M.I.

持有人出生日期: \_\_\_\_月 \_\_\_\_日 \_\_\_\_年 與病人關係: \_\_\_\_\_  
 Subscriber's DOB MM DD YY Relationship to Patient

I AUTHORIZE, DR. LEE TO SUBMIT ALL CLAIMS ON MY BEHALF. I ALSO AUTHORIZE ASSIGNMENT OF BENEFITS DIRECTLY TO HIS OFFICE AND RELEASE OF ANY RECORDS REQUESTED BY MY INSURANCE CARRIER(S). I ALSO ACKNOWLEDGE THAT IF PAYMENT IS NOT RECEIVED THAT I WILL BE HELD RESPONSIBLE FOR THE ENTIRE BALANCE OF THE BILL. I AGREE TO BE RESPONSIBLE FOR ANY COLLECTION AND COURT COSTS SHOULD MY ACCOUNT BE TURNED OVER TO AN ATTORNEY OR COLLECTION AGENCY. I AGREE TO PAY \$20.00 FOR ANY RETURNED CHECK.

SIGNED (簽名): \_\_\_\_\_ DATE (日期): \_\_\_\_/\_\_\_\_/\_\_\_\_