

Advanced Dermatology & Dermatologic Surgery, P.C.

HYUN-SOO LEE, M.D. DIANA K. SUN, M.D. CARING CHAN, D.O.
AHMET ALTINER, M.D. MILENA BONILLA, R-PAC EMMANUEL C. AGNANT, R-PAC

500 Grand Ave., Suite 201, Englewood, NJ 07631 TEL: (201) 886-9000
41-61 Kissena Blvd., Concourse Level, Suite 5A, Flushing, NY 11355 TEL: (718) 886-9000
220 E 161st St, Bronx, NY 10451 TEL: (718)292-9197

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 你的保險需要專疹單看專科嗎? 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): **X** _____ DATE (日期): ____/____/____