Advanced Dermatology & Dermatologic Surgery, P.C.

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Date: _____ /_____ /_____ Soc. Sec. #: _____ – _____ – _____

Name: _____ _____ _____
Last First M.I.

Street Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Age: _____ Date of Birth: _____ /_____ /_____ Marital Status: ☐ Single ☐ Married ☐ Others Sex: ☐ Male ☐ Female

Contact #1: (_____) _____ – _____ Contact #2: (_____) _____ – _____

Emergency Contact: _____ Emergency Phone: (_____) _____ – _____

Referring Doctor: _____ Phone: (_____) _____ – _____

Patient Employer: _____ Work Phone: (_____) _____ – _____

Employer Address: _____ City, State, Zip _____

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.

Primary Insurance **Does your insurance require a referral to see a specialist? ☐ Yes ☐ No**

Insurance Carrier: _____ Insurance ID #: _____

Subscriber's Name: _____ _____ _____
Last First M.I.

Subscriber's DOB: _____ /_____ /_____ Relationship to Patient: _____

Secondary Insurance (If Applicable)

Insurance Carrier: _____ Insurance ID #: _____

Subscriber's Name: _____ _____ _____
Last First M.I.

Subscriber's DOB: _____ /_____ /_____ 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: X_____ **DATE:** _____/_____/_____