

Advanced Dermatology & Dermatologic Surgery, P.C.**HYUN-SOO LEE, M.D., F.A.A.D.****DIANA K. SUN, M.D., F.A.A.D****MILENA BONILLA, R-PAC; JOSHUA SHAPIRO, R-PAC**

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220 E 161st St, Bronx, NY 10451 (718)292-9197

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

Home Phone: (_____) _____ - _____ Cellular Phone: (_____) _____ - _____

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:** _____ **DATE:** ____ / ____ / ____