

Advanced Dermatology & Dermatologic Surgery, P.C.

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Date: ____/____/____

Soc. Sec. #: _____ - _____ - _____

성명 (영문): _____
Name Last (성) First (이름) M.I.

Street Address: _____ Apt. #: _____

주소
City: _____ State: _____ Zip: _____

나이: ____ 생년월일: ____ 월 ____ 일 ____ 년 결혼여부: 미혼 기혼 기타 성별: 남 여
Age Date of Birth: MM DD YY Marital Status: Single Married Other Sex: Male Female

전화번호 1 : (_____) _____ - _____ 전화번호 2 : (_____) _____ - _____
Contact #1 Contact #2

응급시 연락자 성명: _____ 응급시 연락처: (_____) _____ - _____
Emergency Contact Emergency Phone

주치의: _____ 주치의 연락처: (_____) _____ - _____
Referring Doctor Phone

직장이름: _____ 직장 번호: (_____) _____ - _____
Patient Employer Work Phone

직장 주소: _____ City, State, Zip _____
Employer Address

이메일 주소 (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

보험 이름: _____ 가입 번호: _____
Insurance Carrier Insurance ID #

보험 가입자: _____ _____
Subscriber's Name Last (성) First (이름) M.I.

가입자 생년 월일: ____ 월 ____ 일 ____ 년 환자와의 관계: _____
Subscriber's DOB MM DD YY Relationship to Patient

Secondary Insurance (If Applicable)

보험 이름: _____ 가입 번호: _____
Insurance Carrier Insurance ID #

보험 가입자: _____ _____
Subscriber's Name Last (성) First (이름) M.I.

가입자 생년 월일: ____ 월 ____ 일 ____ 년 환자와의 관계: _____
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 (서명란): **X** _____ DATE (날짜): ____/____/____