

# 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

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

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

집 전화 번호: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_    휴대전화: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Home Phone                      Cellular Phone

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): \_\_\_\_\_    DATE (날짜): \_\_\_\_/\_\_\_\_/\_\_\_\_