

Advanced Dermatology & Dermatologic Surgery, P.C.

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Fecha: ____/____/____ # Soc: _____ - _____ - _____

Nombre: _____
Name Apellido Primer Segundo Inicial

Direccion: _____ Apt. #: _____

Ciudad: _____ Estado: _____ Codico Postal: _____

Edad: ____ Fecha de Nacimiento: ____/____/____ Estado Civil: Soltero Casado Otro Sex: Baron Hembra
Age Date of Birth: MM DD YY Marital Status: Single Married Other Male Female

#Telefonico de la Casa: (____) _____ - _____ # del celular: (____) _____ - _____
Home Phone Cellular Phone

Contacto de Emergrncia: _____ Telefono : (____) _____ - _____
Emergency Contact Emergency Phone

Referencia de doctor: _____ Telefono:(____) _____ - _____
Referring Doctor Phone

Patron Paciente: _____ Telefono: (____) _____ - _____
Patient Employer Work Phone

Direccion del trabajo: _____ Ciudad, Estado, Codico Postal: _____
Employer Address
Email: _____ @ _____

Idioma Preferido : 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.

Seguro Primario **Requiere su seguro un remision a ver una especialista?** Yes No

Seguro: _____ # del Seguro: _____
Insurance Carrier Insurance ID #

Nombre del suscriptor: _____ _____ - _____
Subscriber's Name Apellido Primer Segundo Inicial

Fecha de nacimiento del suscriptor: ____/____/____ Relacion a paciente: _____

Seguro Secundario (If Applicable)

Seguro: _____ # del Seguro: _____
Insurance Carrier Insurance ID #

Nombre del suscriptor: _____ _____ - _____
Subscriber's Name Apellido Primer Segundo Inicial

Fecha de nacimiento del suscriptor: ____/____/____ Relacion a paciente: _____

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.

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Fecha : ____/____/____