

# Advanced Dermatology & Dermatologic Surgery, P.C.

HYUN-SOO LEE, M.D., F.A.A.D.

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 220 E 161<sup>st</sup> St, Bronx, NY 10451 (718)292-9197

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.**

Firma: \_\_\_\_\_

Fecha : \_\_\_\_/\_\_\_\_/\_\_\_\_