Bay Area Skin Cancer Surgery and Dermatology

PATIENT INFORMATION:

Name (last, first): _____ Marital Status: _____

Social Security #: _____ / _____ / _____ Date of Birth: ____ / ____ / ____ Gender: _____

Preferred Language: (please circle) English Spanish Other: _____

Please select race: White American Indian/Alaskan Native Asian Black or African American
Native Hawaiian or other Pacific Islander Other Race Unspecified

Please select ethnic group: Not Hispanic or Latino
Hispanic or Latino

CONTACT INFORMATION:

Preferred Contact Method: (please circle) Phone Email Letter Fax

Emergency Contact: Full Name: _____ Phone #: _____

Spouse: Full Name: _____ Phone #: _____

Caretaker: Full Name: _____ Phone #: _____

Phone Numbers: Home: _____ Work: _____

Mobile: _____

Preferred Phone: (please circle) Home Mobile Work **Is it OK to leave a detailed message? Y N**

Email Address: _____

Home Address:

_____
(street)

_____
(city)

_____ _____
(zip code) (state)

Seasonal Address:

_____
(street)

_____
(city)

_____ _____
(zip code) (state)

If applicable, please list employer's name: _____ and occupation: _____

INSURANCE INFORMATION:

Primary Insurance: _____

Policy Holder: Self _____ Other _____

Insured's Relationship to Patient: _____

Policy Holder's Date of Birth: _____/_____/_____

ID Number: _____

Group Number: _____

Effective Date: _____ Term Date: _____

Secondary Insurance: _____

Policy Holder: Self _____ Other _____

Insured's Relationship to Patient: _____

Policy Holder's Date of Birth: _____/_____/_____

ID Number: _____

Group Number: _____

Effective Date: _____ Term Date: _____

BAY AREA SKIN CANCER SURGERY AND DERMATOLOGY

YOUR LOCAL PHARMACY INFORMATION:

Name of pharmacy:_____

Phone Number: _____

Street:_____ Zip code:_____

Name of Referring Physician: _____ Phone #: _____

Name of Primary Care Physician: _____ Phone #: _____

AUTHORIZATION TO BILL: I hereby authorize Bay Area Skin Cancer Surgery and Dermatology, L.L.C. to bill my insurance companies listed above. _____ (patient initials)

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Bay Area Skin Cancer Surgery and Dermatology, L.L.C. to release any information required in the course of my examination or treatment, which could include photographs, HIV, communicable diseases, drug abuse information, or a letter regarding the care I have received, to any of the referring doctors listed above. _____ (patient initials)

AUTHORIZATION TO PAY: I hereby authorize payment directly to Bay Area Skin Cancer Surgery and Dermatology, L.L.C. for surgical and/or medical evaluation and treatment. I understand that I am financially responsible for the charges not covered by my insurance. _____ (patient initials)

PRIVACY POLICY, PATIENT RIGHTS: I hereby acknowledge that I have seen/reviewed the "Notice of Privacy Policy" and the Florida Patient's Bill of Rights and Responsibilities displayed in the waiting room. I have been given an opportunity to ask questions regarding these documents, and understand that I may have a paper copy should I so desire. _____ (pt initials)

Signature (patient or guardian): _____ Date: _____ / _____ / _____