
Advanced DermCare, P.C.

NAME _____ DATE OF BIRTH _____ MARITAL STATUS _____
HOME ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME PHONE _____ CELL PHONE _____
E-MAIL ADDRESS _____ S.S.# _____ SEX _____
WORK/PATIENT'S EMPLOYER _____ WORK PHONE _____
WORK ADDRESS _____

May we leave messages about your medical care and your appointments with us on your home answering machine? Y/N

We will normally discuss your healthcare matters only with you. If you would like to authorize us to speak with others concerning your healthcare, please write their full names and their relationship to you in the space provided. If you do not wish anyone else to be able to have access to this information, please write, 'NONE'.

PERSONAL PHYSICIAN _____
REFERRING PHYSICIAN _____ ADDRESS _____
RESPONSIBLE PARTY IF PATIENT IS A MINOR _____
ADDRESS _____
RELATIONSHIP _____ PHONE _____
**I hereby request and authorize the physicians of Advanced Dermcare, P.C. to examine and treat minor child:
(Print name of child) _____
Parent or Guardian Signature _____ Date _____

INSURANCE INFORMATION

PLEASE PRESENT YOUR INSURANCE CARD AT EVERY OFFICE VISIT.

PRIMARY POLICY HOLDER'S NAME _____ PRIMARY POLICY HOLDER'S DATE OF BIRTH _____
PRIMARY INSURED EMPLOYER _____ PRIMARY INSURED S.S. # _____
NAME OF PRIMARY INSURANCE COMPANY _____ COPAY AMOUNT _____
PATIENT'S INSURANCE ID# _____ GROUP # _____ DEDUCTIBLE, if any _____
SECONDARY INSURANCE COMPANY _____
SEC. INS. POLICY HOLDER'S NAME _____ SEC. INS. POLICY HOLDER'S DOB _____
SECONDARY INSURED EMPLOYER _____ SEC. INS. POLICY HOLDER'S SS# _____
PATIENT'S SECONDARY INSURANCE ID# _____ GROUP # _____
COPAY AMOUNT _____ DEDUCTIBLE, if any _____

OFFICE POLICY

If my insurance plan requires an authorization for this visit and any follow-up visits, it is my responsibility to ensure that the **referral** is current and on file with Advanced DermCare.

I am aware that my insurance **copay** is to be paid each date of service.

I am aware that if Advanced DermCare does not participate with my plan or if I have no insurance, **payment** must be made on the date of service.

Authorization to Assign Benefits - I hereby authorize insurance payments to be made directly to Advanced DermCare for any services rendered. I agree to pay any balance specified by my insurance plan as my responsibility which may include deductible, coinsurance and non-covered services.

Authorization to release Information - I hereby authorize Advanced DermCare to release any information acquired during my examination or treatment to third-party payors for payment of the charges.

Signature _____ Date _____