Skin and Cancer Associates

Dept. _____

PATIENT INFORMATION

DATE _____ E-MAIL ADDRESS _____

PATIENT NAME (1st) _____ (MIDDLE) _____ (LAST) _____ AGE _____ DATE OF BIRTH _____

SS# _____ DRIVER LIC. NO./STATE _____ ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED ☐ MALE ☐ FEMALE

LOCAL ADDRESS _____ APT# _____ CITY _____ STATE _____ ZIP _____ PHONE [ ] _____

PERMANENT ADDRESS _____ PHONE [ ] _____

PERSON TO PAY BILL _____ RELATIONSHIP _____

ADDRESS _____ PHONE [ ] _____

CELL PHONE [ ] _____

NAME OF SPOUSE [OR PARENT] _____

PATIENT EMPLOYERS _____ OCCUPATION _____ WORK PHONE [ ] _____

ADDRESS _____

SPOUSE/PARENT EMPLOYER _____ WORK PHONE [ ] _____

ADDRESS _____

TO NOTIFY IN CASE OF EMERGENCY _____ RELATIONSHIP _____ PHONE [ ] _____

REFERRED BY _____

INSURANCE INFORMATION

PRIMARY INSURANCE

INS. CO. _____

ADDRESS _____

_____ PHONE _____

POLICY # _____

GROUP # _____

INSURED NAME _____ DOB _____ SEX ☐M ☐F

SECONDARY INSURANCE

INS. CO. _____

ADDRESS _____

_____ PHONE _____

POLICY # _____

GROUP # _____

INSURED NAME _____ DOB _____ SEX ☐M ☐F

AUTHORIZATION TO PAY / FOR MEDICARE, LIFETIME AUTHORIZATION

I authorize any holder of medical or other information about me to release to my insurance company, and, for Medicare/Blue Cross/Blue Shield to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers or to the billing agent of Blue Cross/Blue Shield of Florida, any information needed for this or a related insurance or claim. I permit a copy of this authorization to be used in place of the original. I further authorize payment of medical and/or surgical insurance benefits, otherwise payable to me, to the party who accepts assignment. I understand that I am financially responsible for those charges not paid by my insurance.

PATIENT SIGNATURE _____ DATE _____

OTHER SIGNATURE/REASON, IF PATIENT IS UNABLE TO SIGN _____ DATE _____