

SKIN AND CANCER ASSOCIATES/CENTER FOR COSMETIC ENHANCEMENT®

Today's date:

PATIENT INFORMATION

Patient's last name:		First:		Middle:		☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms ☐ Dr.		Marital status (circle one) Single / Mar / Div / Sep / Wid	
Date of Birth: / /	Age:	Sex: ☐ M ☐ F	Social Security No.: - -			Driver's License No. & State			
Home Phone No: ()		Work Phone No: ()		Cell Phone No: ()		Email Address:			
Local Street Address:			City:		State:		ZIP Code:		
Permanent Street Address:			City:		State:		ZIP Code:		
Occupation:		Employer:							
Name of Parent (for Minor Patient):		Name of Parent Employer:				Parent Work Phone No: ()			
Parent Address (if different)			City:		State:		ZIP Code:		
Referred to practice by:		☐ Dr.		☐ Insurance Plan		☐ Yellow Pages/Advertising:			
☐ Family/Friend:		☐ Web Site:				☐ Other:			

INSURANCE INFORMATION

Person responsible for bill:		Birth date: / /		Address (if different):		Home Phone No.: ()	
Occupation:		Employer:		Employer address:		Employer Phone No.: ()	
Primary Insurance:		Address:				Phone No: ()	
Insured's name:		Insured's S.S. No.:		Birth Date: / /		Sex: ☐ M ☐ F	
						Group No.: Policy No.:	
Patient's relationship to subscriber:		☐ Self		☐ Spouse		☐ Child ☐ Other	
Secondary Insurance (If Any):		Address:				Phone No: ()	
Insured's name:		Insured's S.S. No.:		Birth Date: / /		Sex: ☐ M ☐ F	
						Group No.: Policy No.:	
Patient's relationship to subscriber:		☐ Self		☐ Spouse		☐ Child ☐ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):		Relationship to patient:		Home phone no.: ()		Work phone no.: ()	
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AUTHORIZATION TO PAY/ FOR MEDICARE, LIFETIME AUTHORIZATION

The above information is true to the best of my knowledge. 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 if Patient Unable to Sign

Date