

SKIN AND CANCER ASSOCIATES/CENTER FOR COSMETIC ENHANCEMENT®

Today's date:

PATIENT INFORMATION

Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms <input type="checkbox"/> Dr.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Date of Birth: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> 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: <input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan		<input type="checkbox"/> Yellow Pages/Advertising:		
<input type="checkbox"/> Family/Friend:		<input type="checkbox"/> Web Site:		<input type="checkbox"/> 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: <input type="checkbox"/> M <input type="checkbox"/> F	Group No.:	Policy No.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Secondary Insurance (If Any):		Address:			Phone No: ()	
Insured's name:	Insured's S.S. No.:	Birth Date: / /	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Group No.:	Policy No.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> 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.: ()
----------------------------------------------------------------	--	--------------------------	------------------------	------------------------

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
-------------------	------	-------------------------------------------	------