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	Last 4 digits of Social Security #	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:	Last 4 digits of SSN	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:	Last 4 digits of SSN	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.: ( )

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