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			
❑ Family/Friend		❑ Website:	❑ Other:			

INSURANCE INFORMATION

Person responsible for the 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:	Group No.:	Policy No.:
Patient's relationship to subscriber:	❑ Self	❑ Spouce	❑ Child	❑ Other	
Secondary Insurance (if any):	Address:	Phone No.: ( )			
Insured's Name:	Insured's S.S. No.:	Birth Date: / /	Sex:	Group No.:	Policy No.:
Secondary Insurance (if any):	Address:	Phone No.: ( )			
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

AUTHORIZED TO PAY / FOR MEDICARE LIFETIME AUTHORIZATION

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best to 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 Administrations 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 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