SKIN CANCER CARE SPECIALISTS, LLC
PATIENT REGISTRATION

NAME:_____AGE:_____
LAST FIRST MIDDLE

HOME ADDRESS:_____PHONE:(___)_____

CITY:_____ STATE:_____ ZIP:_____

2ND HOME ADDRESS: _____

OCCUPATION:_____
WORK PHONE:(___)_____

Ethnicity	Race	
Hispanic	American Indian or Alaskan Native	
Non-Hispanic	Asian	Black or African American
Unknown	White	Other:_____

Is it okay to leave messages containing your health information? Yes | No

Date of Birth: _____/____/____ SEX: **Male --Female--Other** SOC. SEC#_____

Emergency Contact:_____ PHONE: (__)_____

Spouse/Parent:_____ Phone:(__)_____

Preferred Language	
English	Spanish
Other:_____	

Pharmacy Name:_____ Phone: (__)_____ Referring Physician:_____
Pharmacy Address:_____ General Practitioner:_____

How were you referred:

Referring Physician	Patient	Direct Mail /Letter	Insurance Plan	Other: _____

Financial Info

Responsible Party:	Self	Spouse	Other

Name: Spouse/Other:_____
Date of Birth: _____

Insurance Carrier Name: _____ Policy # : _____ Group#: _____

Second Insurance Carrier Name: _____ Policy # : _____ Group#: _____

Payment is to be made at the time services are rendered. Any other arrangements must be discussed with the office manager prior to your consultation with the doctor.

I,_____ authorize the release of any medical information requested by my insurance carrier in order to process insurance claims.

Medicare Patients:

I request payment of authorized Medicare benefits be made either to me or on my behalf to Skin Cancer Care Specialist, LLC. for any services furnished to me by that physician. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Patient/Guardian/POA:_____ Date: ___/____/____

MANAGED CARE AND PREFERRED PROVIDER ORGANIZATION (HMO & PPO) PATIENTS:

I understand I am responsible for all deductibles and co-payments at the time of service. I further understand should payment be denied due to "Pre-existing illness", "Non-covered or termination of coverage", I will be responsible for payment of such fees within 30 days of such notification.

Patient/Guardian/POA:_____ Date: ___/___/____