SKIN SURGERY CENTER
SKIN CANCER SPECIALISTS

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NEW PATIENT INFORMATION

Name:_____
(first) *(middle initial)* *(last)*

Date of Birth (*mm/dd/yyyy*) _____ Age _____ Male ☐ Female ☐

Address:_____
(street) *(city)* *(state)* *(zip code)*

Home Phone # (*land line*) : _____ Mobile #: _____ confirmation calls/texts? ☐

Work #: _____ Occupation: _____ Employer: _____

Email:_____
(we use email frequently to communicate appointment information and do NOT send solicited material)

Relationship/Marital Status:

☐ Single
☐ Married | Spouse - name: _____ | *Also your emergency contact?* ☐

Spouse - phone #: _____

*Other Relationship Status (*if you would like to include for your file*): _____

Emergency Contact: _____ Phone: _____Relationship to you: _____

Name of referring physician (*if applicable*):_____

Ethnicity (*check applicable) Optional:*

☐ Caucasian ☐ Hispanic ☐ NOT Hispanic or Latino
☐ African American ☐ Asian ☐ Other _____

INSURANCE INFORMATION

Primary Insurance Company: _____ ID# _____ Group # _____

Insured Name: _____ DOB: _____

Secondary Insurance Company: _____ ID# _____ Group # _____

Insured Name: _____ DOB: _____

The information provided is true to the best of my knowledge. I authorize treatment for myself or the above individual and I understand that I am ultimately responsible for charges associated with medical services and agree to pay all bills upon receipt of the statement, unless other arrangements are made. I authorize the physician to release to my Insurance and its agents any information required to process my insurance claims. I further agree that a copy of this agreement shall be as valid as the original. I authorize my insurance company to pay the provider directly.

Signature: _____ Date: _____