ADVANCED DERMATOLOGY LASER & COSMETIC SURGERY

1220 Avenue P Brooklyn, NY 11229
718-375-7546 (Tel) 718-376-6475 (Fax)

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name:_____ First name:_____
DOB: _____ SS: _____ Sex: ⊙ Male ○ Female
Home Address: _____ Apt:_____ City:_____ State:_____Zip : 67567
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Can we contact you at work? Y○ N⊙
E-mail:_____
Emergency Info: Contact Person:_____Phone Number: _____
Referring Doctor: _____ Phone Number: _____
Race: American Indian ○ Asian ⊙ Black ○ Native Hawaiian ○ Type-Unknown ○ White ○
Ethnicity: Hispanic Origin ○ Non-Hispanic Origin ○ Type-Unknown ⊙
Preferred Language: _____
Smoking Status: Smoker ○ Never Smoker ○ Former Smoker ○ Current Every Day Smoker ⊙

PRIMARY INSURANCE

Name of Insurance Plan: _____Insurance ID#:_____
Employer Name: _____ Address: _____
Work Phone: _____ Can we contact you at work? Y⊙ N○
Relationship to Patient: ▪ Self ☐ Spouse ☐ Child ☐ Other _____

GUARANTOR INFORMATION

Last Name: _____ First name: _____ DOB:_____
SS: _____ Relationship to Patient: ○ Self ○ Spouse ○ Child ⊙ Other_____
Home Address: _____ Home Phone: _____
Employer Name: _____
Employer Address: _____ Work Phone: _____

SECONDARY INSURANCE

Name of Insurance Plan: _____Insurance ID#_____
Name of Insured: _____ DOB:_____
SSN:_____ Relationship to Patient: ☐ Self ▪ Spouse ☐ Child ☐ Other _____
Employer of Insured: _____ Phone: _____

I hereby authorize and direct my physician, having treated me, to release to government agencies, insurance carriers, or others who are financially liable for my hospitalization and medical care, all information needed to substantiate payment for such care and treatment.

I request that payment of authorized benefits be made either to me or on my behalf to Dr. Eyal Levit for my service(s) provided by Advanced Dermatology Laser & Cosmetic Surgery if insurance will deny payment for the service(s).

PATIENT AGREES TO PAY ADVANCED DERMATOLOGY LASER & COSMETIC SURGERY ALL DENIED, UNPAID OR RECOVERED AMOUNTS IF THE LISTED INSURANCE INFORMATION IS DETERMINED TO BE INACCURATE OR INCOMPLETE, INCLUDING, BUT NOT LIMITED TO, BY STATING AN INCORRECT PRIMARY INSURER.

I agree that Advanced Dermatology Laser and Cosmetic Surgery may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

Pharmacy Name: _____ Pharmacy Phone: _____

_____ _____ Apr 10,2014
Patient's Signature Patient's Name (Print) Date

_____ Apr 10, 2014
Signature of Patient's Representative/ Relationship Date

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