AESTHETIC
DERMATOLOGY, P.C.
Center for Laser Surgery and Liposuction

Welcome to our office. In order to serve you properly, we will need the following information. **(Please Print)**
All information will be strictly confidential. Also, please provide the receptionist a picture id and your insurance card

Patient's Name	Sex M F	Birth Date ____/____/_____ Age_____	Marital Status Single **[ ]** Married **[ ]** Widowed [ ] Divorced [ ]
Residence address City State Zip		Home Phone: Cell Phone:	Patient's Social Security #
Person financially responsible for this account	Self Spouse Parent	Responsible Party's Birthdate ____/____/_____	Responsible Party's Social Security #
Responsible Party Drivers License # State: Number		Race/Ethnicity	Email Address
Name of employer Address		Business Phone	Occupation

Name of Spouse/Parent	Birth date	Social security #	Business phone
Name of Primary Care Physician	Referred by: (include address and phone)		
Person to contact in case of emergency:	Relationship to patient	Phone	

Medicare Yes **[ ]** No **[ ]**	Medicare #	Medicaid Yes **[ ]** No **[ ]**	Medicaid #	Effective Date
Medicare Secondary insurance name Address			Policy #	Group #

Primary insurance company Address			Is insurance through your employer?
Subscriber Name	Subscriber birth date	Policy #	Group #
Secondary insurance name Address		Policy #	Group #
Subscriber Name	Subscriber Date of Birth		

Medicare/Medicaid Signature on File:
I request that payment of authorized Medicare/Medicaid benefits be made on my behalf to Aesthetic Dermatology, PC for any services furnished me by the physician and/or medical staff. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information to determine these benefits payable for related services

_____ _____
Patient Signature Date

Private Insurance Authorization for Assignment of Benefits/Information Release and Signature on File:
I, the undersigned authorize payment of medical benefits to Aesthetic Dermatology, PC for any services furnished me by the physician and/or medical staff. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims for medical benefits.

_____ _____
Patient, Parent or Guardian Signature (if child is under 18 years old) Date