DermSurgery Laser Center ● DSA Surgery Center Inc. ● DermSurgery Associates, P A.

Paul M. Friedman M.D. **Leonard H. Goldberg, M.D.**
Arash Kimyai-Asadi M.D. **Ming Jih M.D.**

PATIENT INFORMATION

Please Print

Today's Date:_______________ **Please circle : Male/Female**

Last name:_________________________First Name:____________________Middle Initial:___

Home address:______________________City:________________________State_____Zip____

Home Phone:___________________Daytime Phone:____________________Cell: ____________

Social Security #____________________Date of Birth:_______________Marital Status: S/M/D/W

Employer's Name:_____________________________________Position:_____________________

Employer's Address:_____________________City:____________________State_____Zip________

Primary Care Physician:__________________________Referring Physician:__________________

Emergency Contact Person:______________________________Home Phone:_________________

Work Phone:_________________Cell Phone______________________Relationship____________

Can we contact you via email? Yes___ No____ Signature__________________________________

Email address: ____

INSURANCE INFORMATION

Primary Insurance Company:_______________________________Phone:____________________

Address:____________________________City:___________________State:_____Zip:_________

Insured Name:_____________________Date of birth_________________ SS#__________________

Policy#:____Group#:________

Secondary Insurance Company:______________________________Phone:_____________________

Address:____________________________City:________________Phone:____________________

Insured Name:___________________________Policy#:______________Group#:________________

NOTICE TO MANAGED HEALTH CARE PARTICIPANTS

As a Managed Health Care patient it is <u>YOUR RESPONSIBILITY</u> to identify yourself as a PPO HMO or POS patient to our secretary <u>EACH TIME</u> you visit our office.

If your POS or HMO plan required for you to obtain pre-authorization from your primary care physician or patient advocate, please provide our office with this information prior to your visit with the doctor, in order to obtain the highest level of benefits. If you fail to obtain prior authorization as directed by your plan you will be responsible for payment at the time services are rendered.

I hereby authorize payment of insurance benefits to be paid directly to DermSurgery Associates / DSA Surgery Center for any services furnished to me. I authorize DermSurgery Associates to release information to Health Care Financing Administration and its agents, Medicare Champus, or any commercial insurance carrier covered by insurance or prepayment programs.

SIGNATURE:____DATE:___________________