DERMATOLOGY & SKIN CANCER CENTERS

SKIN AND MOHS SURGERY CENTER

WELCOME TO OUR OFFICE

If this is your first visit to our office, please bear with us in filling out this information sheet. This sheet provides us with information vital to your health and will aid our office in accurately filing your insurance forms. Be assured that this information will remain strictly confidential. Please note this form is two-sided. We ask that you attempt to complete each blank as fully as possible.

PATIENT INFORMATION:

Today's Date _____

Patient's Full Name _____ Marital Status S ___ M ___ W ___ D ___

Social Security # _____ Birth Date _____ Age _____ Sex: M _____ F _____

Street Address _____ City, State _____ Zip _____

Patient's Home Phone (_____) _____ Patient's Business Phone (_____) _____

Employer _____ Occupation _____

What county do you live in? _____ E-Mail: _____

SPOUSE INFORMATION:

Name _____ Social Security # _____

Spouse's Employer _____ Spouse's Business Phone (_____) _____

Does spouse have medical insurance coverage through his/her employer? ☐ yes ☐ no

STUDENTS AND MINOR PATIENTS:

Mother's Name _____ Father's Name _____

Mother's Address _____ Father's Address _____

Mother's Employer _____ Father's Employer _____

Home Phone (_____) _____ Bus. Phone (_____) _____ Home Phone (_____) _____ Bus. Phone (_____) _____

Name of Student's School _____ School Address _____

Permanent Mailing Address _____

MEDICAL INSURANCE: ☐ HMO ☐ PPO ☐ CO-PAY $ _____

Primary Company _____ Secondary Company _____

Insured (Subscriber) _____ Insured (Subscriber) _____

Insured's Relationship to Patient _____ Insured's Relationship to Patient _____

Insured's Social Security # _____ Insured's Social Security # _____

Insured's Date of Birth _____ Insured's Date of Birth _____

Certificate or ID # _____ Certificate or ID # _____

Group or Policy # _____ Group or Policy # _____

Effective Date (Date coverage began) _____ Effective Date (Date coverage began) _____

Preferred Laboratory _____

Family Doctor _____ Last Visit _____
Last First

Referring Doctor _____ Last Visit _____
Last First

PLEASE READ AND SIGN OTHER SIDE OF PAGE

Patient Name _____

Due to state reporting requirements, please provide us with the following information:

1) Race: ☐ Caucasian ☐ African American ☐ American Indian
☐ Asian ☐ Other _____

2) Ethnicity: ☐ Hispanic ☐ Non-Hispanic

AUTHORIZATION FOR PHOTOGRAPHS

I consent to photographs being taken for my health record.

Signature of Patient _____ **Date** _____

AUTHORIZATION TO RELEASE MEDICAL BENEFITS

I authorize the release of all medical information necessary to process insurance claim(s) and I hereby assign and authorize direct payment of all medical and/or surgical benefits, including major medical, private insurance and other health plans to the undersigned.

Dermatology & Skin Cancer Specialists, P.A.
Skin & Mohs Surgery Center
Leawood, KS • Lee's Summit, MO • Belton, MO • Liberty, MO • Kansas City, MO

Please remember that medical insurance is considered a method of deferred payment and is not a substitution for payment. It is your responsibility to pay any deductible amount, co-insurance or any other balance deemed patient responsibility by the insurance company. It is your responsibility to pay the balance in full if the insurance information you provide us proves false or otherwise ineffective. It is your responsibility to follow all guidelines of your insurance company, including the obtaining of referrals as necessary if your coverage is through an HMO. You must inform our office prior to receiving service if your insurance coverage is through an HMO. Information regarding any change in your insurance coverage must be provided prior to receiving service.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record.

This Assignment will remain in effect until revoked by me in writing. A signed photocopy of this Assignment is to be considered as valid as an original.

Signature of Patient _____ **Date** _____

Signature of Responsible Party _____ **Date** _____

MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made on my behalf to Dermatology & Skin Cancer Specialists, P.A. or Skin & Mohs Surgery Center for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services.

Signature of Beneficiary: _____ **Date** _____

LIFETIME CONSENT

I request that payment of authorized Medigap benefits be made on my behalf to Dermatology & Skin Cancer Specialists, P.A. or Skin & Mohs Surgery Center for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Beneficiary: _____ **Date** _____

Medigap Insurer: _____ **Patient's Medigap #:** _____