Z-ROC DERMATOLOGY
Medical, Aesthetic and Surgical Specialists

SKIN AND CANCER ASSOCIATES

Today's date:

PATIENT INFORMATION

Patient's last name: First: Middle: ○ Mr. ○ Miss ○ Mrs. ○ Ms ○ Dr.

Marital status (check one) ☐ Single ☐ Mar ☐ Div ☐ Sp ☐ Wid

Date of Birth: Age: Sex: Social Security No.: Driver's License No. & State

Home Phone No: Work Phone No: Cell Phone No: Email Address:

Local Street Address: City: State: ZIP Code:

Permanent Street Address: City: State: ZIP Code:

Occupation: Employer:

Name of Parent (for Minor Patient): Name of Parent Employer: Parent Work Phone No:

Parent Address (if different) City: State: ZIP Code:

Referred to practice by: ☐ Dr. ☐ Insurance Plan ☐ Yellow Pages/Advertising: ☐ Family/Friend: ☐ Web Site: ☐ Other:

Name of local friend or relative (not living at same address): Relationship to patient: Home phone no.: Work phone no.: (

AUTHORIZATION TO PAY/ FOR MEDICARE, LIFETIME AUTHORIZATION

The above information is true to the best of my knowledge. I authorize any holder of medical or other information about me to release to my insurance company, and, for Medicare/Blue Cross/Blue Shield to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers or to the billing agent of Blue Cross/Blue Shield of Florida, any information needed for this or a related insurance or claim. I permit a copy of this authorization to be used in place of the original. I further authorize payment of medical and/or surgical insurance benefits, otherwise payable to me, to the party who acepts assignment. I understand I am financially responsible for those charges not paid by my insurance.

Patient Signature Date Other Signature if Patient Unable to Sign Date