SKIN CANCER CTR C FL-OCALA

(352) 873-7788

DATE: _____

INSTRUCTIONS:

Please Print Legibly & Fill In or Correct All Fields

Print N/A for "Not Applicable" in blank fields

Patient's Name _____ Male/Female

Last First Middle Birthdate Age Gender

Marital Status ❒ Single ❒ Widowed ❒ Married to _____ ❒ Other _____

Florida Address _____

Street & Apt # City State Zip

Out of state address _____

Street & Apt # City State Zip

Home Phone ( ) _____ **Emergency Contact**

Cell Phone _____ Name _____

Other Phone _____ Related how _____

E-mail _____ Phone _____

Preferred Language: ❒English ❒ Spanish ❒ French ❒ German ❒ OTHER_____

Smoking Status: ❒ Current every day smoker ❒ Current some day smoker ❒ Never smoker ❒ Former smoker ❒ Smoker, current status unknown ❒ OTHER_____

Race: ❒American Indian or Alaska Native ❒ Black or African American ❒ Asian ❒ Native Hawaiian or Other Pacific Islander ❒White/caucasion ❒ OTHER

Ethnicity: ❒ Non Hispanic or Latino ❒Hispanic or Latino ❒ OTHER (specify)_____

Prefer Contact by: ❒Cell ❒ Work ❒ Home ❒ Email ❒ OTHER_____

Primary Care Physician **Phone** (if known)

Health Insurance Information

	PRIMARY INSURANCE	SECONDARY INSURANCE	THIRD INSURANCE
Company			
Insured Party	**Insured Party**	**Insured Party**	
Name			
DOB			

Preferred Pharmacy Phone Fax

I authorize the following individual(s) to discuss my records and/or receive copies of my records.
print name(s) here:

I understand that office visit charges are payable on the day service is rendered. I authorize The Skin Cancer Center of Central Florida, PA to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between the Skin Cancer Center of Central Florida, PA and myself.

Signature _____ **Date** _____

Patient Signature

Signature _____ **Date** _____

Skin Cancer Center Witness

OFFICE USE ONLY - ❒ Data updated in EMR SCANNED: ❒ Driver's License ❒ Insurance Card INIT_____

SCC ID#: 1113302