SKIN CANCER CENTER CENTRAL FL

(352) 259-6553

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