CENTER FOR LASER AND DERMATOLOGIC SURGERY

PATIENT INFORMATION

Date: ________________

Name:____ Gender _________________

Date of Birth: __________________ Social Security #**:** _______________________________________

Address: ____
street city state zip

Home phone: __________________________________ Cell phone: _______________________________

For Patient Portal Access: Email Address ____

✱ **FEDERAL GOVERNMENT REQUIREMENT** Race: _________ Ethnicity: _________ Decline ☐

Emergency Contact: ________________________________ **Phone Number:**______________________

Referring Doctor: ____

Primary Care Physician: ____

Pharmacy, Name and Location:____

INSURANCE INFORMATION

	Primary Insurance	**Secondary Insurance**
Health Insurance Co:	___________________________	_______________________________________
Policy #::	___________________________	_______________________________________
Group #:	___________________________	_______________________________________
Subscriber's Name.:	___________________________	_______________________________________
Relationship to Patient:	___________________________	_______________________________________

(HAVE YOU COMPLETED BOTH SIDES?)

Insured's or Authorized Person's Signature

I authorize the release of any medical or other information necessary to process this claim to my insurance company.

____

I authorize payment of medical benefits and/or government benefits to Yehuda D. Eliezri, M.D./ Edward B. Desciak, M.D. for services rendered.

____

I have been notified that should it become necessary to send any outstanding balances to a collection agency, the patient will be responsible for any fees incurred by this office.

____

IF the Drs. DO NOT participate in your health insurance plan, please sign.

I have been notified that Dr. Eliezri and Dr. Desciak do not participate in my health insurance plan.

I understand that I am responsible for any fees that are incurred at this office.

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Center for Laser and Dermatologic Surgery
Yehuda D. Eliezri, M.D. Edward B. Desciak, M.D.
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