Skin & Laser Center of NJ

Patient Information Sheet

Name: _____ SS#: _____

Date of Birth: _____ Age: _____ Sex: M F Marital Status: S M W D Sep

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Mobile #: _____ Work #: _____

Email address: _____

Referring Doctor or How You Found Us: _____

Primary Physician (PCP): _____ PCP Street Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact Name: _____ Phone #: _____

Employer: _____

Language: _____ Hispanic (specify) or non-Hispanic: _____ Race: _____

PRIMARY INSURANCE COVERAGE:

Insurance Co: _____ Policy #: _____

Group #: _____ Specialist Copayment: _____ Subscriber's Employer: _____

Subscriber name: _____ Subscriber DOB: _____ Relationship: _____

Subscriber's address: _____ City: _____ State/Zip: _____

SECONDARY INSURANCE COVERAGE:

Insurance Co: _____ Policy #: _____

Group #: _____ Specialist Copayment: _____ Subscriber's Employer: _____

Subscriber name: _____ Subscriber DOB: _____ Relationship: _____

Subscriber's address: _____ City: _____ State/Zip: _____

We will bill your insurance company if we participate with that company. You are responsible for any and all charges that your insurance company does not cover. You are responsible for notifying us of any changes to your insurance. Treatments performed by the doctor (not covered by insurance) are to be paid at the time of the visit. Payments are payable at time of service. Parents are responsible for payments on minor's account. Subscribers will be billed for deductible and/or co-insurance and any additional charges as indicated by EOB. I authorize the insurance payments to go directly to physician and for release of necessary medical records to the insurance company. I understand that all tissue removed will be sent for pathologic examination at additional cost.
Managed care participants: Although we will try to assist you as best we can, it is your responsibility to obtain referrals from your primary care physicians for each visit to our office. Even if a return visit is made for you by our office, your referral may have expired. If you are uncertain if one is current, please call our office to check at least 48 hours before your visit.
I certify that I understand the above and that the information I have given is correct to the best of my knowledge.

X _____ Date: _____

(Patient signature; if minor then parent/guardian must sign)