Advanced Dermatology Associates

Stephen E. Presser, MD
Dermatology and Dermatologic Surgery
Mohs' Surgery for Skin Cancer

DATE**: _____**
Sex: M / F (circle one) Age: _____
Marital Status: _____

Language: _____

Name: _____ Birth Date: _____

Last First MI

Address: _____

Street City State Zip

Email Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Occupation: _____ Address: _____

Insurance (1) _____ Member Id # _____

Insurance (2) _____ Member Id # _____

Name of Policy Holder: _____

Person responsible for payment (if party is a minor) _____

Advanced Dermatology Associates

Name: _____Date of Birth:_____
(your name & DOB, should 2nd page be separated from page 1)

Emergency Contact: _____ Relationship_____

Address: _____ Phone _____

Primary Care Physician: _____ Phone _____

Address: _____

Reason for visit: _____

Medical history (last 5 years or anything of significance): _____

_____

Current medications: _____

_____

Allergies: _____

Pharmacy: _____ Phone: _____

I understand and agree that, regardless of my insurance status, I am responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and have completed the above questions. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information. It is agreed that the signature below is an authorization for assignment of benefits to Advanced Dermatology Associates on all / any insurance claim forms.

Signature _____ Date _____
(Patient or responsible party)