Advanced Dermatology
Thomas J. Hoffmann, M.D.
Surgical & Medical Offices, Inc.

Date: _____

Patient Name_____Age: _____

Social Security #_____Date of Birth: _____Sex _____

Marital Status (circle one) Single Married Widowed Divorced Separated

Preferred Language _____Ethnicity/Race _____

Home Address _____
Street City State Zip
Home Telephone _____Cellular Telephone_____

Email Address _____

Emergency Contact _____Telephone _____

Patient Employer _____Telephone _____

If patient is a minor, fill in responsible parent or guardian:

Responsible party _____Relationship_____Telephone _____

Pharmacy Information:

Pharmacy Name _____Telephone _____

Street Address _____City _____State _____Zip _____

Insurance Information

Insurance Carrier _____Member ID _____

Name of Subscriber _____Date of Birth _____SS# _____

Secondary Carrier _____Member ID _____

Name of Subscriber _____Date of Birth _____SS# _____

Payment for services rendered is to be made as follows:
"I request that payment of authorized insurance benefits be made to Advanced Dermatology, Thomas J. Hoffmann, M.D., Surgical & Medical Offices, Inc. services or items furnished to me by the physician/supplier. I authorize the practice to release to the Health Care Financing Administration (HCFA/CMMS), my Insurance Carrier, and/or its agent's appropriate information needed to determine these benefits or the benefits payable for related services, in accordance with HIPPA guidelines. Release of other information requires specific release authorization. I am financially responsible for appropriate deductibles, copayments, and non-covered items (which have been explained to me from information supplied by my carrier). If this account has to be turned over to an attorney due to delinquency or non-payment, I will be responsible for all costs of collection including the court costs and reasonable attorney fees."

_____ _____
Signature of Beneficiary or Parent/Guardian Date