

CARY L. DUNN, MD, PA

SKIN CANCER SPECIALIST™

New Patient Name Change Address Change Insurance Change

THIS SECTION MUST BE COMPLETED BY ALL PATIENTS:

Name _____
Last First M.I.

Date of Birth: ___/___/___ Age: _____ Sex: Male Female SS# _____-_____-_____

ADDRESS:

Mailing Address _____
Street City State Zip

Northern Address _____

Home Phone: () _____ Work Phone: () _____

Cell Phone: () _____ e-mail: _____

Emergency Contact: _____ Phone _____

Name/Relationship

Any Restrictions on contacting you? _____

Do we have permission to discuss your medical condition or test results with any member of your household?

Yes No Comments: _____

How did you hear about us? Radio Television Flyer Skin Cancer Screening

Newspaper / If so which one? Herald Tribune Desoto Sun Peace River Shopper

Other: _____ Physician Referral _____

INSURANCE CARRIER INFORMATION:

Primary Insurance Carrier: _____

Secondary Insurance Carrier: _____

PRIMARY INSURANCE HOLDER *MUST HAVE*** (if different from patient)**

Name: _____ Home Phone: () _____
Last First M.I.

Address: _____
Street City State Zip

Date of Birth: ___/___/___ Social Security Number _____

PLEASE SIGN SO WE MAY HAVE YOUR INSURANCE AUTHORIZATION AND RELEASE OF INFORMATION ON FILE

I authorize any holder of medical or other information about me to release to the above insurance company(s) any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. I further authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims.

Date: ___/___/___ Signature: _____

I ACKNOWLEDGE THAT I HAVE READ AND AGREE TO THE Cary L. Dunn MD, PA Office Financial Policy and that I HAVE READ AND CONSENT TO THE Cary L. Dunn MD, PA Notice of Privacy Practice (HIPPA) Policy.

Date: ___/___/___ Signature: _____

Please provide your insurance card(s), co pay and driver's license to the receptionist along with this form.