Atlantic Dermatology, LLC
1980 N. Atlantic Ave Suite 722
Cocoa Beach, Florida 32931
(321) 784-8811

PLEASE PRINT
DATE: _____

****PLEASE PRESENT DRIVER'S LICENSE AND INSURANCE CARDS FOR COPYING***

NAME _____
Last First Middle

ADDRESS _____ APT. _____

CITY _____ STATE _____ ZIP _____

Age _____ Birthdate _____ Sex _____ Social Security Number_____

Home Phone _____ Cell Phone _____ Work Phone _____

Which number would you prefer we call? Home _____ Cell _____Work_____

Employer _____ Employer Address _____

(Circle One) Name of Spouse / Parent / Guardian / Significant other _____

Work Phone _____ Cell Phone _____

Medical Insurance:

Primary _____ Secondary_____

Insurance Authorization and Permission for Medical Care:
My signature is authorization to file insurance. I understand that I am fully responsible for payment of services rendered even if I have insurance and I will be responsible for any co-payment and amount applied to my deductible. I authorize the release of any medical information necessary to process any claim. I hereby give Dr. Kristin Smallwood permission to examine me for the purpose of making a diagnosis. I further permit and request that she perform the test and procedures she deems necessary and she and I agree are appropriate for medical care.

_____ _____
Patient / Parent / or Guardian Signature Date

- SEE REVERSE -

ATTENTION MEDICARE PATIENTS

We are required to keep your signature on file, authorizing us to file claims to medicare for you and to release information that the payer requires for the proper consideration of a claim. Please read and sign the following statement.

I authorize any holder of medical or other information about me to release to the Social Security Administration and the Centers for Medicare and Medicaid Services (or its intermediaries or carrier) any information needed for this or a related Medicare 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 to the party who accepts assignment. Regulations pertain to Medicare assignment of benefits only apply.

_____

Signature as it appears on Medicare Card

_____

Date

If you have a supplemental policy and it is a Medi gap policy to which your Medicare carrier automatically “crosses over”, we are required to keep a separate signature on file:

I request authorized Medi gap benefit be made on my behalf for the services furnished to me. I authorize any holder of medical information to release to the above Medi gap carrier any information needed to determine these benefits or the benefits payable for related services.

_____

Signature as it appears on Medi gap Card

_____

Date