Sukal Skin Institute

Name: _____ Male/ Female:_____ DOB: _____ Age: _____

Florida Address: _____
(Street Address) (City) (State) (Zip)

Phone: _____ Cell Phone: _____

Email:_____

Marital Status: Single □ Married □ Divorced □ Separated □ Widow (er) □

Social Security Number _____

Employer: _____ Employer Phone:_____ Ext _____

Employer Address: _____

Spouse: _____ Spouse Date of Birth:_____

Spouse Social Security Number: _____

Spouse Employer:_____ Spouse Employer Phone: _____

If other than patient is responsible for payment: (This does not include insurance company)

Name: _____ Phone: _____

Relationship to Patient: _____ Date of Birth:_____

Insurance is a contract between you and your insurance company. In MOST cases, we are NOT a party to this contract. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary. You are responsible for the timely payment of your account. Any account 90 days or more past due will incur reasonable collection and / pr attorney fees.

Primary Insurance Co:_____ ID#_____

Secondary Insurance Co: _____ ID#_____

Family Doctor: _____ Doctor's Phone: _____

Referred By: _____

How did you hear about our office: _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

□ I will allow messages to be left on my □ Cell Phone □ Home Phone Regarding office appointments.

□ I will allow messages to be left on my □ Cell Phone □ Home Phone regarding information relating to my health.

□ I will allow you to contact me via email for educational / promotional purposes.

□ I will allow my health information to be discussed with _____

By signing this form, I accept full responsibility for all charges not covered by my insurance (deductibles, co-payments, etc)

Signature:_____ Date: _____