

**ADVANCED LASER & SKIN CANCER CENTER, LLC**

**Gangaram Ragi, M.D., Director**

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Website: www.mohsnj.net

**PATIENT INFORMATION**

Name \_\_\_\_\_ Date \_\_\_\_\_  
Last Name First Name Middle Initial

Address \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Circle: Married Widowed Single Minor Separated Divorced Partnered Occupation \_\_\_\_\_

Referring Physician \_\_\_\_\_ Email \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

In case of emergency who should be notified? \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

**PRIMARY INSURANCE**

Subscriber Name \_\_\_\_\_  
Last Name First Name Middle Initial

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address (If different from patient's) \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_

Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

**SECONDARY INSURANCE**

Subscriber Name \_\_\_\_\_  
Last Name First Name Middle Initial

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address (If different from patient's) \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_

Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

**ASSIGNMENT OF BENEFITS • FINANCIAL AGREEMENT**

If under age 18, Responsible Party Name \_\_\_\_\_

I hereby give lifetime authorization for payment of insurance benefits to be made directly to \_\_\_\_\_, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Responsible Party Date

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Responsible Party Relationship to Patient