

# DERMATOLOGY

**AND SKIN SURGERY CENTER, P.A.**

DEAN R. GOODLESS, M.D.

410 CELEBRATION PL STE 301, CELEBRATION, FL 34747

APPOINTMENT TIME		APPOINTMENT DATE		REFERRAL/SOURCE	
NAME (LAST, FIRST MI)				DATE OF BIRTH	AGE
LOCAL ADDRESS			CITY, STATE, ZIP		SEX
HOME PHONE		DAY PHONE		CELL PHONE	
ACCOUNT NO.	EMAIL			SSN	

PRIMARY INSURANCE COMPANY				INS COMPANY CODE	
INSURED		INSURED DOB	RELATIONSHIP	EFFECTIVE FROM	
ADDRESS OF INSURANCE		POLICY NUMBER	COPAYMENT (PATIENT RESPONSIBILITY) AMOUNT: PERCENT:		
CITY, STATE, ZIP		GROUP NUMBER	DEDUCTIBLE (PATIENT RESPONSIBILITY) AMOUNT: APPLIED:		
PATIENT BALANCE DUE		FAMILY BALANCE DUE		INSURANCE BALANCE DUE	
SECONDARY INSURANCE COMPANY				INS COMPANY CODE	
INSURED		INSURED DOB	RELATIONSHIP	EFFECTIVE FROM	
ADDRESS OF INSURANCE		POLICY NUMBER	COPAYMENT (PATIENT RESPONSIBILITY) AMOUNT: PERCENT:		
CITY, STATE, ZIP		GROUP NUMBER	DEDUCTIBLE (PATIENT RESPONSIBILITY) AMOUNT: APPLIED:		

PATIENT WILL SEND DETAILS OF INSURANCE VIA  
INSURANCE COVERAGE CONFIRMED

FAX  EMAIL

SOURCE:  OTHER MD  OTHER PATIENT  INS. CO. BOOK  YELLOW PAGES  OTHER:

PLEASE NOTE ANY CHANGES BELOW: