Neil S. Heskel, M.D.
865 37th PL
Vero Beach, FL 32960

Welcome: PLEASE PRINT: Today's Date:_____

First Name: _____MI___ Last Name_____

Birth Date_____ Age _____ Social Security# _____ - ____ - _____

Male◯ Female◯ Marital Status: Single◯ Married◯ Widowed◯ Divorced◯

Address_____City_____State_____Zip_____

Home Phone (_____)_____ Cell Phone (_____)_____

Employer _____Occupation _____

Employer Address _____Work Phone (_____)_____

Person Responsible for Payment _____Relationship to Patient _____

Address _____

Employer _____ Home Phone (_____)_____ Cell Phone (_____)_____

PRIMARY (Family) PHYSICIAN _____Referred by _____

Primary Insurance _____ID# _____Group# _____

Secondary Insurance _____ID# _____Group# _____

Subscriber Name _____Subscriber Birthdate _____

PLEASE DESCRIBE YOUR SKIN PROBLEM(S) _____

_____

List Any Treatments Already Tried (including over-the-counter remedies) _____

_____

List ALL Medications you are taking NOW (including vitamins, birth control pills, etc.) _____

_____

_____

List any ALLERGIES _____

_____

Have you ever had… Skin Cancer □Melanoma □Basal Cell □Squamous Cell

□Hepatitis □HIV □Surgery □Cancer Do you have a Pacemaker? _____

Are there any other significant medical problems we should know about? _____

_____

Permission for Medical Care

I hereby authorize medical and surgical evaluation and treatment, and assume financial responsibility. I request that benefits be paid on my behalf to Dr. Neil Heskel. I understand that referral to a specialist is not a guarantee of payment, and my insurance may refuse to pay for my physician. I understand that I am financially responsible for all co-payments and fees not covered by my insurance contract as well as any collection expenses. I authorize the release of all medical information required for submission of insurance claims and the taking of confidential photographs as necessary.

_____

Signature Patient/or Parent/or Guardian Date