STEVEN M. HACKER, MD PA
230 George Bush Blvd., Delray Beach, FL 33444
Email: info@palmbeachdermasurgery.com
Tel: (561) 276 – 3111 Fax: (561) 926 - 9525

Name_____ SSN _____
Last First MI

Mailing Address_____
City State Zip Code

Date of Birth _____/_____/_____ Age _____ Sex: M / F Marital Status _____

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

Employer_____ Occupation_____

Spouse Name_____ Date of Birth _____/_____/_____

PARENT OR RESPONSIBLE PARTY (If Different From Patient)

Name_____ SSN _____
Last First MI

Date of Birth _____/_____/_____ Sex: M / F Home Phone (_____)_____

Mailing Address_____
City State Zip Code

Race: ☐American Indian or Alaska Native
☐Asian
☐Black or African American
☐Native Hawaiian or Other Pacific Islander
☐White
☐Other

Ethnicity: ☐Hispanic or Latino
☐Not Hispanic or Latino

Primary Language: ☐English ☐Other_____

INSURANCE INFORMATION (Please Present Insurance Card at Time of Check-In)

Primary Insurance Name_____ Secondary Insurance Name _____

Name of Policy Holder_____ Date of Birth _____/_____/_____

Relationship of Patient to Policy Holder_____

In case of an emergency contact _____ Phone (_____) _____

Referred By: □ Doctor □ Patient □ Google □ Pinnacle Care □ News □ Top Doctors Website □ Other

Please specify _____

I hereby request the professional services of Dr. Hacker, Dr Saff, Dr Glaun and staff, and agree to financial responsibility as indicated in the paragraph below: I understand that this office will only file insurance claims to plans in which they participate. If I am covered by a plan that they do not participate in, payment will be expected of me at the time of service. I authorize the release of medical information necessary to process claims, and also authorize payment of medical benefits to the physician. If my insurance does not pay, I will be financially responsible for payment in full. Any account with an unpaid balance will be charged interest in the amount of 2.0% per month until such time the account has been paid in full, including any attorney's fees and any other collection costs associated with collection of unpaid balance.

Signature of Patient or Legal Guardian_____ Date_____/_____/_____