Arizona Premier Dermatology
4545 East Chandler Boulevard, Suite 305 | Chandler, Arizona 85048
Phone: (480) 785-7546 | Fax: (480) 940-1760
Email: Info@AZPremierDerm.com | Website: AZPremierDerm.com

PATIENT REGISTRATION FORM

PLEASE FILL OUT COMPLETELY AND PRINT CLEARLY

FULL NAME: ______________________ DOB: __________ AGE: ______

SOCIAL SECURITY# (LAST 4 DIGITS): __________ MARITAL STATUS: __________ SEX: __________

MAILING ADDRESS: ______________________

CITY: ______________________ STATE: __________ ZIP: ______

HOME PHONE: ______________________ CELL PHONE: ______________________

I agree to allow Arizona Premier Dermatology to leave detailed messages/test results on my voicemail at the above number(s) (PLEASE CHECK AT LEAST ONE PHONE NUMBER ABOVE)

I do NOT wish for Arizona Premier Dermatology to leave detailed messages/test results on my voicemail.

EMAIL ADDRESS: ______________________

EMPLOYER: ______________________ WORK PHONE: ______________________

PRIMARY CARE PHYSICIAN: ______________________ PHYSICIAN PHONE: ______________________

EMERGENCY CONTACT PERSON: ______________________ EMERGENCY CONTACT PHONE: ______________________

DO YOU AUTHORIZE THIS OFFICE TO DISCUSS YOUR CARE/TREATMENT WITH ANY OTHER PARTIES BESIDES YOURSELF?

YES NO IF YES, NAME & PHONE NUMBER: ______________________

TO BILL YOUR INSURANCE COMPANY PROPERLY - PLEASE FILL OUT COMPLETELY!

OUR STAFF WILL NEED TO PHOTO COPY ALL INSURANCE CARDS, FRONT & BACK.

PRIMARY INSURANCE: ______________________ ID/GROUP #: ______________________

POLICY HOLDER'S NAME/RELATION TO PATIENT: ______________________ POLICY HOLDER DOB: __________

SECONDARY INS (IF ANY): ______________________ ID/GROUP #: ______________________

POLICY HOLDER'S NAME/RELATION TO PATIENT: ______________________ POLICY HOLDER DOB: __________

RELEASE and ASSIGNMENT

I, the undersigned have insurance coverage and assign directly to Arizona Premier Dermatology all medical benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by said insurance, unless assignee has executed an agreement with my insurance provider or plan. I understand that if such agreement has been executed, I am responsible to pay any deductible and/or co-payment and non-covered services under the terms of my insurance. I understand that I am financially liable in the event of non-payment. I agree to pay the collection agency's cost and/or court cost and reasonable attorney fees.

I request that payment of authorized Medicare/other insurance company benefits be made either to me or on my behalf to Arizona Premier Dermatology for any services furnished me by that party who accepts assignments/physician. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carries any information needed for this or a related Medicare claim/other insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section I 128B of the Social Security Act and 31 U.S.C 3801-3812 provides penalties for withholding this information).

BY SIGNING BELOW, I AGREE THAT ALL OF THE ABOVE INFORMATION IS CORRECT.

Signature: ______________________ **Date:** ______________________

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INSURANCE ASSIGNMENT AND FINANCIAL POLICY

Please read and sign this statement before we accept assignment of benefits directly from your insurance company. The intentions of this policy are in hopes of avoiding any misunderstandings and facilitate the process of your insurance claim in a timely manner.

IF YOU HAVE A COSMETIC APPOINTMENT AND NEED A MEDICAL QUESTION ADDRESSED, IT WILL BE BILLED THROUGH YOUR INSURANCE INCLUDING ANY RX REFILLS.

PAYMENT POLICY

Medicare:

We are participating providers of the Medicare program. We will accept assignment of all claims. Patients are responsible for meeting their annual deductible and coinsurance responsibilities. We do file with secondary / supplement carriers as a courtesy to our patients.

HMO, PPO or other Managed Care Patients:

You will be responsible for paying your annual deductible, co-payment and charges for any non-covered cosmetic services at time of service. Patients without the required referral from you PCP (Primary Care Physician) at the time of appointment will be asked to reschedule. If you prefer to be seen without the required referral, payment will be due at time of service.

Commercial Patients:

Patients who are covered by private, commercial plans, in which our providers are not contracted, are responsible for all fees. The balance left after payment from your insurance will be billed to you.

CANCELLATION & NO SHOW POLICY

If an appointment is missed and/or not canceled within 24 hours of your scheduled appointment it will result in a $25.00 fee. If you had a procedure or surgery scheduled that was missed and/or not canceled within 24 hours prior a $50.00 fee will be charged.

INSUFFICIENT FUNDS POLICY

I understand and agree that if a check is returned for insufficient funds, I will be charged $30.00.

By signing below, I agree that I have read and reviewed all of the above information.

____ ____________________
Signature of Patient or Guardian Date

NOTICE OF PRIVACY PRACTICES

I have read the *Authorization for Release of Health Care Information* form and was offered/provided a copy for my records.

____ ____________________
Signature of Patient or Guardian Date

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MEDICAL HISTORY

Update Your Medical History For Our Records

Patient Name: ______________________________ **DOB:** ______________

Whom can We Thank for Your Referral? ______________________________

Pharmacy Name: ______________________ **Pharmacy Phone #: (_____)** ______________

Medication Allergies: ______________________________
____

Current Medications (including vitamins/topicals): ______________________________
____

Medical History: ______________________________
____

Surgeries/Year: ______________________________
____

Personal History of Skin Cancer (type and area of body): ______________________________
____

Family History of Skin Cancer (type and relationship): ______________________________
____

Number of Years in Arizona? ________ **Sun Exposure in Your Lifetime (check one):** **Mild** **Moderate** **Frequently**

Date of Last Skin Exam: ______________________________

Signature: ______________________________ **Date:** ______________