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 l 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:** _____