Patient Registration Form

Arizona Dermatology Group

PATIENT INFORMATION

Legal Name: _____ ☐ Jr. ☐ Sr.
First Middle Last

Sex: ☐ Male ☐ Female Date of Birth: _____/_____/_____ Social Security #: _____

Mailing Address:_____
Street City State Zip

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

Email Address: _____ Ethnicity & Race: _____ Preferred Language: _____

MARITAL INFORMATION Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name: _____ D.O.B.: _____/_____/_____ Social Security #:

_____ **MINOR INFORMATION (17 YEARS AND YOUNGER)**

Legal Guardian/Parent Name: _____ Date of Birth: _____/_____/_____

Legal Guardian/Parent Social Security #: _____ Phone: (_____)_____

INSURANCE INFORMATION

Do you have insurance? ☐ Yes ☐ No If yes, please completely fill out below to ensure payment:

Primary Insurance: _____ID#:_____ Group #: _____Exp:_____

Secondary Insurance: _____ID#:_____Group #: _____Exp: _____

Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Parent ☐ Other

If **NOT** self, please complete with POLICY HOLDER information:

Policy Holder Name: _____ Date of Birth: _____/_____/_____

Social Security #: _____ Phone: (_____)_____Employer of Policy Holder: _____

Address if different from patient:_____
Street City, State Zip

Are you covered under any other health care plan? Yes No

Are you enrolled in a Medicare Advantage Plan? Yes No

Have you made any changes to your choice of Medicare options in the last open enrollment period? Yes No

May we leave personal medical information on your answering machine at home? ☐ Yes ☐ No

Do you give us permission to discuss your medical information with family members? ☐ Yes ☐ No

If Yes, please provide names: _____

In case of an emergency whom should we notify? Name: _____ Phone: (_____)_____

Who is your primary care physician (PCP): _____ PCP's Phone Number: _____

I have received services by another provider for the condition for which I seek treatment today and I will promptly disclose any necessary information to my insurance carrier to resolve any issues they may have. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information. YOU ALSO ACKNOWLEDGE YOU HAVE OBTAINED, UNDERSTAND, AND AGREE TO ABIDE BY THE GUIDELINES CONTAINED IN THE RELEASE INFORMATION AND PATIENT FINANCIAL POLICY.

_____ _____

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE/PARENT **DATE**