PRECISION DERMATOLOGY
13640 N. 99th Ave, #300, Sun City, AZ 85351
Phone # 623-875-2600

Please fill out this form as completely and accurately as possible

PATIENT INFORMATION: TODAY'S DATE:_____

First Name:_____ Last Name:_____ Marital Status: S____ M____ W____ D____

Social Security #: _____ Date of Birth: _____ Age:_____ Sex: M____ F____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Alternate Address: _____ City: _____ State: ____ Zip: _____

To respect your privacy, please tell us which of the following numbers we should call to communicate with you regarding appointment reminders, lab results, etc. ONLY list the phone number (or numbers) you want us to call.

Home: _____ Okay to leave detailed message: Y_____ N_____

Cell Phone: _____ Okay to leave detailed message: Y_____ N_____

Work: _____ Okay to leave detailed message: Y_____ N_____

Email: _____

Please list any family members or any other person that the staff can communicate with regarding your medical or insurance issues.

Name: _____ Phone: _____

Occupation: _____ Employer: _____

Employer Address: _____ City: _____ State: ____ Zip: _____

Spouse's Name: _____ SS#: _____ Date of Birth: _____

Spouse's Employer: _____ Spouse's Business Phone: _____

Person to contact in case of emergency: _____ Phone: _____

Primary Insurance: _____ **Secondary Insurance: _____**

Insured (Subscriber): _____ Insured (Subscriber): _____

Relationship to Insured: _____ Relationship to Insured: _____

Insured Date of Birth: _____ Insured Date of Birth: _____

Policy ID #: _____ Policy ID #: _____

Group #: _____ Group #: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Pharmacy: _____ Phone: _____

AUTHORIZATION TO BILL INSURANCE: I authorize **Precision Dermatology** to bill my insurance companies listed above. _____ **Initials**

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize **Precision Dermatology** to release any information required in the course of my examination or treatment, which could include pictures, HIV, communicable disease, drug abuse information or a letter regarding the care I have received with Precision Dermatology to Precision Dermatology or any of my referring doctors listed above. _____ **Initials**

AUTHORIZATION TO PAY: I hereby authorize payment directly to Precision Dermatology for the surgical and/or medical benefits, if any, otherwise payable to be for services. _____ **Initals**

I have received and understand my Patient Rights and Notice of Privacy Practices given to me by **Precision Dermatology.** _____ **Initials**

I understand that I am financially responsible for the charges not covered by my insurance. _____ **Initials**

Signed (Patient or Guardian) : _____ Date: _____