

**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. \_\_\_\_\_ **Initials**

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: \_\_\_\_\_