Pima Dermatology, PC

New Pt ____ Update____

REGISTRATION FORM

Last Name:___________________________First______________________ M I ____ Social Security#_______________________

Address____City_________________ State__________ Zip___________

Date of Birth______________________ Age: ___________ Sex: M F Marital Status: S M D W

Home Phone_______________________ Cell Phone________________________Email___________________________________

May we leave messages at home/cell numbers _____ yes _____ no Messages at work number _____yes _____no

Responsible Party (PATIENT is RESPONSIBLE PARTY IF OVER 18 Yrs of Age)
Last Name(If different than above):__________________________________ First_________________________ M I________
Address(If different than above):____Ph#____________________

Emergency Contact:______________________________Relationship__________________PH#___________________________

Who may we share information with? ____ PH# _______________________

GUARANTOR INFORMATION

Parent/ Guarantor ____ Employer____________________________________

Work Address____City_________________ State__________ Zip___________

Work Phone ____ May we leave messages at work number _____yes _____no

Spouse Occupation _____________________________________ Employer____

How did you hear about us? ( ) Friend __________________ ( ) Insurance ( ) Internet ( ) Phone book ( ) Other_______________

Referring Doctor:___________________________ Ph#____________________Primary Doctor:____________________________

INSURANCE INFORMATION

Primary Insurance:_____________________________Address:____

Policyholder's Last Name:______________________________First:________________________ SS#________________________

Date of Birth_______________Sex M F Policy ID#______________________________Group#___________________________

Relationship to Policyholder: ( )Self ( )Spouse ( )Son ( )Daughter Deductible___________ Co-Pay $_____________

Secondary Insurance:____________________________Address:____

Policyholder's Last Name:______________________________First:________________________ SS#________________________

Date of Birth_______________Sex M F Policy ID#______________________________Group#___________________________

Relationship to Policyholder: ( )Self ( )Spouse ( )Son ( )Daughter Deductible___________ Co-Pay $_____________

I authorize Pima Dermatology to release medical information needed for insurance processing and I further authorize insurance benefits be paid directly to Pima Dermatology. I agree to pay all fees incurred and/or not covered by insurance benefits paid to Pima Dermatology, P.C.

For your convenience, Pima Dermatology accepts assignment with many frequently used insurance plans with which we are contracted. However, please be aware payment for the charge incurred is YOUR responsibility if your carrier denies the claim for reasons beyond our control. Payment is expected at time of service for all patients not covered by insurance carriers with whom we Are contracted. If you cannot pay in full, special arrangements MUST be made. Insurances do not cover cosmetic services. Cosmetic care, products and supplies must be paid at time of the visit.

____ ____________________
Signature Date