PiMA DERMATOLOGY

ADULT / PEDIATRIC / COSMETIC / LASER & SKIN SURGERY

Patient Information:

Legal Name: Last: _____ First: _____ Middle: _____

Preferred *First* Name (if applicable): _____ Date of Birth: ____/____/_____ Sex: M ☐ F ☐

Race/Ethnicity: _____ Language Preference: _____

Address _____City _____ St _____Zip_____

Referral Information: How did you learn about our office?

Provider: _____ Friend / Family: _____ Other: _____

Contact Information:

Home Phone: ( ) _____ - _____ Cell Phone: ( ) _____ - _____ Email: _____

Which is your primary contact preference? Home _____ Cell _____ Email _____ * *Please read our email disclosure statement below.*

Emergency Contact: _____ Relationship: _____ Ph # ( ) _____ - _____

Your Primary Care Physician's Name: _____

Insurance Information: (please fill out all information below)

Primary Insurance: _____ Member ID #: _____

Policy Holder's Name (if other than yourself): _____ Date of Birth: _____/_____/_____

Relationship to Policy Holder? ( ) Self ( ) Spouse ( ) Child

Secondary Insurance: _____ Member ID # _____

Policy Holder's Name (if other than yourself): _____ Date of Birth: _____/_____/_____

Relationship to Policy Holder? ( ) Self ( ) Spouse ( ) Child

Responsible Party Name: Last Name: _____ First :_____ Middle: _____

Address: _____City: _____ St: _____ Zip:_____

I certify that all information provided above is accurate to the best of my knowledge. I authorize Pima Dermatology, P.C. to release medical information needed for insurance processing and/or to another medical provider for continuity of care purposes. I further authorize insurance benefits to be paid directly to Pima Dermatology. I agree to pay all fees incurred and/or not covered by insurance benefits paid to Pima Dermatology. I am aware that payment for the charge incurred is MY responsibility if my carrier denies the claim for reasons beyond Pima Dermatology's control. It is my duty to check with my insurance company to see what services are covered before my visit. I am aware that payment is expected at time of service for all patients not covered by insurance carriers with whom we are contracted. If I cannot pay in full, I am aware that special arrangements MUST be made in advance. I am aware that insurance plans do not cover cosmetic services. Cosmetic care, products, and supplies must be paid at time of the visit. I acknowledge that I have the right to read and review payment or other policy information upon request before signing this consent and at any time during office hours. **Regarding email communications, I consent to receiving limited email communications from Pima Dermatology and understand that all email messages are sent over the Internet and are not encrypted; therefore, there is the potential that emails may be accessed by others. Limited communications include, but are not limited to, appointment confirmations, acknowledgements, requests to contact the office, and promotional events and offers. No lab results or personal health information will be disclosed via telephone or email.*

Signature: _____ **Date:** _____/_____/_____

PLEASE BRING THIS 1st PAGE TO THE RECEPTIONIST WITH INSURANCE CARDS & PHOTO ID BEFORE CONTINUING ON