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How did you hear about us?

Referring Doctor: _____

() Insurance () Internet () Phonebook () Friend _____ () Other _____

Patient Information:

Last Name _____ First _____ M _____ Social Security # _____

Address _____ City _____ St _____ Zip _____

Date of Birth ____/____/____ Age _____ Sex M F Race/Ethnicity _____ Language Preference _____

Home Phone _____ Cell Phone _____ Email _____

Which do you prefer as your primary contact? Home or Cell May we leave messages? Yes No

Emergency Contact _____ Relationship _____ Ph # _____

Whom may we share information with? _____

Primary Doctor _____ Ph # _____

Insurance Information:

Primary Insurance _____ Policy ID # _____ Group # _____

Policy Holder's Last Name _____ First _____ Date of Birth ____/____/____

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

Secondary Insurance _____ Policy ID # _____ Group # _____

Policy Holder's Last Name _____ First _____ Date of Birth ____/____/____

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

I certify that all information provided above is accurate to the best of my knowledge. I authorize Pima Dermatology to release medical information needed for insurance processing and 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, P.C. 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. I acknowledge that I have the right to read and review an extended payment policy before signing this consent and at anytime during office hours.

Signature _____ Date _____