PiMA DERMATOLOGY

ADULT / PEDIATRIC / COSMETIC / LASER & SKIN SURGERY

Patient Information:

Last Name ________________________________ First ______________________ Middle________________

Date of Birth ____/____/________ Sex ( )M or ( )F Race/Ethnicity _______________ Language Preference ______________

Address ____ City _____________ St _____ Zip ____________

Contact Information:

Home Phone ( ) ________ - _________ Cell Phone ( ) ________ - _________ Email ______________________________

Do you authorize us to send limited communications via telephone? Yes _____ No _____ Via email?* Yes _____ No _____

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

Emergency Contact ________________________________ Relationship ______________ Ph # ( ) _____ - _________

Who do you authorize our office to share information with? ____

Your Primary Care Physician's Name? ________________________________

Referral Information:

Who told you about our office? (please be specific) ____

(provider) (friend) (family member) (internet search) (n/a)

If applicable, may we use your name when thanking your referral source? ( ) Y or ( ) N

Insurance Information: (please fill out all information below)

Primary Insurance ____________________________________ Policy ID # ____________________________________

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

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

Secondary Insurance ________________________________ Policy ID # ______________________________________

Policy Holder's Name (if other than yourself): ____________________________________ 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, 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 verify network participation and covered services with my insurance company 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 an extended payment policy 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