Arizona Skincare Physicians, P.L.C.

PATIENT REGISTRATION FORM

____ ________________ ☐ M ☐ F
Last First Middle Date of Birth & age

____
Home address City State Zip

___________________ ______________________ _________________________
Home Phone # Work Phone # Cell Phone #

___________________ S / M / W / D ___________________________
Social Security # Marital Status Patient's Email Address

____
Patient's Employer

____
How did you hear about us

Insurance Information- Please allow us to photocopy your insurance card(s)

____
Insured party's name SS # Date of Birth Employer

____
Insured Party's Address City State Zip

____
Relationship to Insured

If patient is a minor, name and address of responsible party for payment: ______________________________

Primary Insurance Company Name: ____

Do you have a secondary insurance coverage? Yes ___ No ___ If so, with whom?________________________

____
Name of person to contact in emergency Phone #

____
Primary Care Physician Phone #

____
Referring Physician Phone #

****

I herby certify that the above information is correct.

____ ______________
Patient/Guardian Signature Date

REV. 05/10 WEB

Arizona Skincare Physicians, P.L.C.

Patient/Responsible Party Responsibility Agreement

- I fully understand that I am financially responsible for any and all charges incurred regardless of insurance. (The actual charges allowed for the services you receive are often determined by the specific policies and procedures of the medical insurance plan(s) of which you are a member.)
- I understand that co-pays are to be paid before seeing the doctor.
- I understand payment for other services are expected at the end of each visit unless other arrangements have been made.
- I understand that if Arizona Skincare Physicians is not a participant in my insurance plan, I will be responsible for payment on the day of service, and that Arizona Skincare Physicians will file my claim with my insurance plan for my eventual reimbursement to the extent that I am eligible for reimbursement.
- **I understand that if my insurance requires a referral it is my responsibility to make sure a current referral is on file. I further understand it is my responsibility to contact my PCP for any referrals needed.**
- Any check that is returned as Non Sufficient Funds a $25.00 fee will be charged, and we will only accept cash, money order or credit card to cover any outstanding balance.
- Some services may require the use of **an outside laboratory and will be billed under a different provider**.
- I understand that medical insurance may not pay my entire bill and that I will receive a bill for the portion of the fees that are my responsibility. I understand that if I have a balance due that is more than 30 days old I will be charged a monthly interest fee of 1.5% (i.e. 18% annually) on this balance. I further understand that I am responsible for all collection and or attorney fees if necessary to collect this debt.

Patient Name:____

Patient/Responsible Party Signature:________________________________Date:____________________

Authorization for Direct Payment for Medical Services and Release of Medical Records to process claims

- I hereby authorize payment directly to Arizona Skincare Physicians. I further authorize the release of any medical information necessary to process such claims.
- This Agreement shall remain in full force and effect until written notice to the contrary is provided by the undersigned. I hereby acknowledge that I will be personally responsible for payment of assigned insurance benefits when they are not paid within sixty (60) days of filing a completed claim and when adequate information to determine whether the insurance will pay the charges is unavailable.

Patient/Responsible Party Signature: X________________________________ Date: ____________________

ARIZONA SKINCARE PHYSICIANS, P.L.C.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, **Arizona Skincare Physicians, PLC** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to **Arizona Skincare Physicians**, PLC's Notice of Privacy Practices for a more complete description of such uses and disclosures.
I have the right to review the Notice of Privacy Practices prior to signing this consent.

Arizona Skincare Physicians, PLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Arizona Skincare Physicians, PLC's** Privacy Officer at 10565 N. Tatum Blvd., Paradise Valley, AZ 85253.

With my consent, **Arizona Skincare Physicians, PLC** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, **Arizona Skincare Physicians, PLC** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, **Arizona Skincare Physicians, PLC** may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that
Arizona Skincare Physicians, PLC restricts how it uses or discloses my PHI to carry out TPO.
However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **Arizona Skincare Physicians, PLC's** use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **Arizona Skincare Physicians, PLC** may decline to provide treatment to me.

____
Signature of Patient or Legal Guardian

______________________________ ____________________
Patient's Name Date

____
Print Name of Patient or Legal Guardian

Arizona Skincare Physicians, P.L.C.

Dermatology Medical History

Patient Name: ____ Date:______________

Reason for visit today: ____

Allergic to:				Please list other drug allergies:
	Lidocaine	☐ yes	☐ no	______________________________
	Tape	☐ yes	☐ no	______________________________
	Polysporin	☐ yes	☐ no	
	Epinephrine	☐ yes	☐ no	

Please list medications you are currently taking, including prescription, over-the-counter, vitamins, and herbals:

____

____

DERMATOLOGY HISTORY

When exposed to the sun do you ☐ tan only ☐ tan & burn ☐ burn?

Have you ever been diagnosed with a skin cancer? ☐ No ☐ Yes -- what type? ____________when? ____________

Family members diagnosed with a skin cancer? ☐ No ☐ Yes -- who? ______________type? ____________

Have you ever had an abnormal mole/nevus removed? ☐ No ☐ Yes Please list__________________________

Do you have a history of any specific skin diseases? ☐ No ☐ Yes Please list__________________________

____

MEDICAL HISTORY

Do you have now, or have you ever had diseases or conditions of:

	Yes	No		Yes	No
Asthma	☐	☐	Diabetes	☐	☐
Allergic rhinitis	☐	☐	Blood disorder	☐	☐
Eczema	☐	☐	Liver disorder	☐	☐
Heart murmur	☐	☐	Thyroid disorder	☐	☐
Artificial Valve	☐	☐	Kidney disorder	☐	☐
Blood clots	☐	☐	Arthritis/joint deformity	☐	☐
Pacemaker	☐	☐	Artificial joint	☐	☐

List any other diseases or conditions:____

____

Surgical procedures in the last 6 months?____

____

SOCIAL HISTORY

Do you drink alcohol? ☐ Yes ☐ No If yes, ______ drinks per day.

Do you use IV drugs? ☐ Yes ☐ No If yes, what? ____________ How much? ____________

Do you smoke? ☐ Yes ☐ No If yes, ______________ per day.

Have you had or have you been exposed to HIV (AIDS)? ☐ Yes ☐ No

Do you bleed easily? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Due date: ______________

Occupation ____

List your hobbies: ____

____

Signature/Patient ____________________________________