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| PATIENT INFORMATION | | | | |
| PATIENT NAME: LAST FIRST MI | | SOCIAL SECURITY NUMBER | | |
| MAILING ADDRESS STREET/ PO BOX APT# | | DATE OF BIRTH | SEX (CIRCLE)  FEMALE MALE | |
| CITY STATE ZIP CODE | | HOME# | CELL # | |
| E-MAIL | | MARITAL STATUS (CIRCLE)  SINGLE DIVORCED MARRIED WIDOW PARTNER | | |
| RACE (CIRCLE): CAUCASIAN AMERICAN INDIAN ALASKAN NATIVE  ASIAN AFRICAN AMERICAN NATIVE AMERICAN PACIFIC ISLANDER  OTHER | | ETHNICITY (CIRCLE)  HISPANIC NON HISPANIC | | |
| 2ND SEASONAL ADDRESS: STREET OR PO BOX APT# CITY STATE ZIP CODE | | | | |
| PHARMACY NAME: | | PHARMACY PHONE: | | PHARMACY CROSS STREETS |
| MAY WE LEAVE PERSONAL MEDICAL INFORMATION ON YOUR VOICE MAIL (CIRCLE)?  YES NO / HOME CELL | | | | |
| PERSON RESPONSIBLE FOR CHARGES | | | | |
| If person responsible for payment is different from patient, then complete below.  If patient is a child please indicate if parents are (circle): MARRIED SEPARATED DIVORCED | | | | |
| FULL NAME | | SOCIAL SECURITY NUMBER | | |
| MAILING ADDRESS | | DATE OF BIRTH | | |
| CITY STATE ZIP | | PREFERRED NUMBER TO CONTACT | | |
| PATIENT RELATIONSHIP TO RESPONSIBLE PARTY(CIRCLE):  SPOUSE CHILD OTHER | | WORK PHONE | | |
| REFERRAL INFORMATION | | | | |
| PRIMARY CARE PHYSICAN | NAME OF REFERRING PHYSICAN | | | |
| EMERGENCY CONTACT INFORMATION | | | | |
| IN CASE OF EMERGENCY NOTIFY (FULL NAME): | PHONE | | | |
| INSURANCE INFORMATION | | | | |
| **PRIMARY INSURANCE**  INSURANCE NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  POLICY/ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  GROUP/ACCOUNT# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  RELATION TO PATIENT : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **SECONDARY INSURANCE**  INSURANCE NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  POLICY/ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  GROUP/ACCOUNT# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  RELATIONSHIP TO PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| I hereby certify the above information is true and correct to the best of my knowledge. I also understand it’s MY responsibility to understand my insurance coverage. I further understand that A to Z Dermatology will assist me in obtaining authorization from primary care physician or insurance company. However, if authorization is not obtained I may be financially responsible. I acknowledge that photo IDs taken are used to assist in patient recognition per HIPPA guidelines. I authorize A to Z Dermatology to release any medical information including diagnosis, test results, reports and records pertaining to any treatment or examination rendered to me. I authorize payment of medical benefits to A to Z Dermatology.  **PATIENT OR RESPONSIBLE PARTY SIGNATURE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE** \_ | | | | |

**www.atozdermatology.com**