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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 NATIVEASIAN AFRICAN AMERICAN NATIVE AMERICAN PACIFIC ISLANDEROTHER | 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** \_ |

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