A to Z Dermatology

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	**SECONDARY INSURANCE**
INSURANCE NAME: _____	INSURANCE NAME: _____
POLICY/ID#_____	POLICY/ID# _____
GROUP/ACCOUNT# _____	GROUP/ACCOUNT# _____
DOB:_____ SS# _____	DOB: _____ SS# _____
RELATION TO PATIENT : _____	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** _