SKIN and CANCER CENTER of Arizona

An Established Tradition of Medical Excellence

NAME:

____
Last First MI Prefix Suffix Nick Name

PATIENT PHONE NUMBERS

______________________ ______________________ ______________________
Home Work Mobile

PREFERRED PHONE: □ Home □ Work □ Mobile

IS IT OK TO LEAVE A DETAILED MESSAGE? □ Yes □ No

MARITAL STATUS:
□ Annulled □ Common Law □ Divorced □ Domestic Partner □Interlocutory
□ Legally Separated □ Living Together □ Married □ Registered Domestic Partner □ Separated
□ Single □ Unknown □ Unmarried □Widowed □ All other

SOCIAL SECURITY NUMBER: ________-_______-________

DATE OF BIRTH: _______-_______-_________

Place of Birth: ____
City State Zip Code Country

SEX: □ Female □ Male

LANGUAGE___________________________________ □ Declined to specify
□ Prohibited by state law

RACE AND ETHNIC GROUP: ___________________ □ Declined to specify
□ Prohibited by state law

Ethnic Group: □ Declined to specify □ Prohibited by state law □ Hispanic or Latino
□ Not Hispanic or Latino □ Unknown

PREFERRED CONTACT METHOD:

□ Declined to receive reminders □ Phone □ Letter

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CONTACT INFORMATION

EMERGENCY CONTACT

______________________________ ______________________________
Full Name Phone Number

SPOUSE

______________________________ ______________________________
Full Name Phone Number

CARETAKER

______________________________ ______________________________
Full Name Phone Number

EMAIL ADDRESSES

______________________________ ______________________________
Email Address Alternate Email

ADDRESSES: Please enter your home address and if you have one, a seasonal address

____
Home Address Apt/Unit# City State Zip

____
Seasonal Address Apt/Unit# City State Zip

Start Date: ________________ End Date: ____________________

EMPLOYER: If applicable, complete the following about your employer

Employment Information: ______________________________
Employer’s name

____
Occupation

____
Industry

Custom Message:

____

____

____

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Advanced Medical Plaza • 725 South Dobson Road, Suite#200 • Chandler, Arizona 85224 • PHONE (480) 899-7546 • FAX (480) 899-7599

Primary Care Doctor:

Name: ____ Phone # _______________________

Address: ____

INSURANCE:

Primary Health Insurance Company: ____

Policy # _______________________ Group # _________________ Ins Phone # ______________

Referral Required? □Yes □ No

Policy Holder Name: ______________________________________DOB: ___________________

____Phone # ________________
Address Apt/Unit#

Relationship to Patient: □ Spouse □ Child □ Other _________________

Secondary Health Insurance Company: ____

Policy # _______________________ Group # _________________ Ins Phone # ______________

Referral Required? □Yes □ No

Policy Holder Name: ______________________________________DOB: ___________________

____Phone # ________________
Address Apt/Unit#

Relationship to Patient: □ Spouse □ Child □ Other _________________

I, the undersigned, have insurance coverage and assign directly to Skin and Cancer center of AZ, P.C. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by said insurance, unless assignee has executed an agreement with my insurance provider or plan. I understand that if such agreement has been executed, I am responsible to pay any deductible and/or co-payment and non-covered services under terms of my insurance. I understand that I am financially liable in the event of non-payment. I agree to pay the collection agency's cost/or court cost and reasonable attorney fee's.

If self-pay I understand that any charges incurred are payable at the time of service. I authorize Skin and Cancer Center of AZ, P.C. to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Skin and Cancer Center of AZ, P.C. and myself.

Signature: ____**Date**: ____________________

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