SKIN and CANCER CENTER of Arizona

An Established Tradition of Medical Excellence

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Patient Information Form

Name: ____ ______________________
Last **First** **MI** **Suffix** **Date of Birth**

____
Home Address **Apt/Unit#** **City** **State** **Zip**

____
Seasonal Address **Apt/Unit#** **City** **State** **Zip**

___________________________ **SEX**: ☐ Female ☐ Male **Marital Status**: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Social Security Number:

PHONE NUMBER: (Please Mark Preferred Phone Number)

☐__________________________ ☐ __________________________ ☐__________________________
Home **Work** **Mobile**

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

Email Address: ____

Employment Information: ______________________________ ______________________
Employer's name **Occupation**

______________________________ ______________________
Address **Industry**

Preferred Language: ☐ English ☐ Other ______________________ ☐ Declined to specify

Race: ☐ American Indian ☐ Asian ☐ Black or African American ☐ White ☐ Other Race ☐ Declined to specify

Ethnic Group: ☐ Hispanic or Latino ☐ Not Hispanic or Latin ☐ Unknown ☐ Declined to specify

RESPONSIBLE PARTY IF PATIENT IS A MINOR

______________________________________ ______________________
Full Name **Relationship to Patient**

______________________________________ ______________________
Full Address **Date of Birth**

____
Primary Contact Number

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Patient Name: ______________________

PRIMARY CARE DOCTOR

______________________ ______________________
Full Provider Name **Phone Number**

____
Address

EMERGENCY CONTACT

______________________ ______________________
Full Name **Phone Number**

SPOUSE

______________________ ______________________
Full Name **Phone Number**

CARETAKER

______________________ ______________________
Full Name **Phone Number**

Primary	Secondary
Primary Insurance: ______________________	Secondary Insurance: ______________________
Member ID: ______________ Group: ________	Member ID: ______________ Group: ________
Policy Holder's Information	**Policy Holder's Information**
Policy Holder Name: ______________________	Policy Holder Name: ______________________
Relationship to Patient: ______________________	Relationship to Patient: ______________________
Address: ______________________	Address: ______________________
City: ____________ State: _____ Zip: ________	City: ____________ State: _____ Zip: ________
SS#: ____________ DOB: ____________	SS#: ____________ DOB: ____________
Insurance through Employer? □ Yes □ No	Insurance through Employer? □ Yes □ No
Policy Holder Employer: ______________________	Policy Holder Employer: ______________________
Employer Phone #: ______________________	Employer Phone #: ______________________
Is a Referral Required? □ Yes □ No □ Unknown	Is a Referral Required? □ Yes □ No □ Unknown

Medicare Patients:

Have you made any changes to your choice of Medicare options in the last Open Enrollment: □ Yes □ No
Are you enrolled in a Medicare Advantage Plan? □ Yes □ No
Are you enrolled in Hospice? □ Yes □ No

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Queen Creek Professional Village • 21321 E. Ocotillo Rd. Suite 124 • Queen Creek, AZ 85142 • PHONE (480) 899-7546 • FAX (480) 899-7599

Patient Name: ____________________

RELEASE AND ASSIGNMENT OF BENEFITS

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 fees.

I authorize the provider to initiate a complaint or file appeal to insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

I request that payment be authorized Medicare/Other Insurance company benefits be made to either to me or on my behalf to Skin and Cancer Center of Arizona, P.C. for any services furnished by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or request payment of Medical Insurance Company claim. I permit a copy of this authorization be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding information.)

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 of Insured/Guardian **Print Name**

If Guardian:

____________________ ____________________

Relationship to Patient **Date**

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