DERMATOLOGY &
SKIN SURGERY
SPECIALISTS

Dermatology & Skin Surgery Specialists
8415 N Pima Road, Suite 212
Scottsdale, AZ 85258
(480) 434-6600
Fax (480) 522-3528
www.skinspecialistsofaz.com

Dear Patient,

Thank you for choosing Dermatology & Skin Surgery Specialists. We are looking forward to seeing you at your upcoming appointment. The following information will assist you with the registration process. In order to expedite the registration process, please complete the included Patient Demographic Form. In addition, you may also compete the full patient registration packet prior to your appointment. The complete registration packet can be found on our website at http://skinspecialistsofaz.com/patient-resources/new-patient-registration-forms. By completing these forms ahead of time, you will save a significant amount of time during your visit.

Please be prepared to provide this information to our office along with your current medical insurance card and a photo identification. If your insurance requires a referral, please bring the referral form with you. If have a specialist co-pay, we will collect that at time of service.

Please arrive 15 minutes prior to your first appointment to allow sufficient time for the registration process. If you would prefer to complete the forms at our office, please arrive 30 minutes prior to your appointment time.

We appreciate your assistance with preparing for your appointment, and we look forward to providing you the highest quality dermatological care. If you have any questions or concerns regarding the registration process, or any questions about your appointment, please do not hesitate to contact our office.

Sincerely,

Anne Goldsberry Walter, MD
Medical Director

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Patient Information

PATIENT NAME: LAST FIRST M.I		SOCIAL SECURITY NUMBER	
MAILING ADDRESS STREET OR PO BOX APT		DATE OF BIRTH GENDER FEMALE ☐ MALE ☐	
CITY STATE ZIP		HOME PHONE	CELL / WORK
EMAIL		MARITAL STATUS: ☐ SINGLE ☐ DIVORCED ☐ MARRIED ☐ WIDOW ☐ PARTNER	
RACE: CAUCASIAN ☐ AFRICAN AMERICAN ☐ AMERICAN INDIAN ☐ ASIAN ☐ NATIVE HAWAIIAN ☐ PACIFIC ISLANDER ☐ OTHER ☐		EITHNICITY: HISPANIC ☐ NON-HISPANIC ☐	
2ND/SEASONAL ADDRESS STREET OR PO BOX		APT CITY STATE ZIP	
PHARMACY NAME:	PHARMACY PHONE:	PHARMACY ADDRESS:	
HOW DID YOU HEAR ABOUT US? GOOGLE ☐ INSURANCE ☐ ZOC DOC ☐ YELP ☐ WEB ☐ PHYSICIAN _____ PATIENT/FRIEND_____ OTHER_____			
MAY WE LEAVE PERSONAL MEDICAL INFORMATION ON YOUR VOICE MAIL? YES ☐ NO ☐ SELECT: HOME ☐ CELL ☐			

PERSON RESPONSIBLE FOR CHARGES

IF PERSON RESPONSIBLE FOR PAYMENTS IF DIFFERENT FROM PATIENT, THEN COMPLETE BELOW:
IF PATIENT IS CHILD, PLEASE INDICATE IF PARENTS ARE: SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐

FULL NAME	SOCIAL SECURITY NUMBER
MAILING ADDRESS STREET OR PO BOX APT	DATE OF BIRTH
CITY STATE ZIP	PREFERRED PHONE NUMBER
PATIENT RELATIONSHIP TO RESPONSIBLE PARTY	WORK PHONE

REFERRAL INFORMATION

PRIMARY CARE PHYSICIAN:	REFERRING PHYSICIAN:

EMERGENCY CONTACT INFORMATION

IN CASE OF EMERGENCY NOTIFY:	PHONE:

MEDICAL RECORD DISCLOSURE

I authorize Dermatology & Skin Surgery Specialists to discuss the following aspects of my care with the following individual(s):

VISIT / DIAGNOSIS ☐ TEST RESULTS ☐ TREATMENT ☐	NAME:	RELATION:

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE NAME	INSURANCE NAME
POLICY/ID#	POLICY/ID#
GROUP/ACCOUNT#	GROUP/ACCOUNT#
CARDHOLDERS NAME	CARDHOLDERS NAME
DOB SSN	DOB SSN
RELATION TO PATIENT	RELATION TO PATIENT

I hereby certify that the above information is true and correct to the best of my knowledge. I understand that while Dermatology & Skin Surgery Specialists contract with many insurance companies, it is MY responsibility to verify with my plan that the physician I am seeing is a participating provider. I further understand that Dermatology & Skin Surgery Specialists will assist me in obtaining authorization from my primary care physician or insurance company if necessary. If however, authorization is not obtained, I may be financially responsible for the services rendered. I hereby authorize Dermatology & Skin Surgery Specialists to submit insurance claim forms along with medical records necessary to obtain payment from my insurance company. I understand that I am responsible for all charges regardless of insurance coverage. I acknowledge that photo IDs taken are used to assist in patient recognition per HIPAA guidelines. I authorize the doctor to release any medical information including diagnosis, test results, reports, and records pertaining to any treatment or examination rendered to me. I understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of information. I authorized payment of medical benefits to Dermatology & Skin Surgery Specialists.

PATIENT OR RESPONSIBLE PARTY SIGNATURE:	DATE:

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Patient History & Intake

PATIENT NAME	DOB	AGE

Past Medical History
(Please check all that apply)

- ☐ Anxiety
- ☐ Arthirtis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ None

Other _____

Past Surgical History
(Please check all that apply)

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy (Right, Left, Bilateral)
- ☐ Lumpectomy (Right, Left, Bilateral)
- ☐ Breast Biopsy (Right, Left, Bilateral)
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ Mechanical Valve Replacement
- ☐ Biological Valve Replacement
- ☐ Heart Transplant
- ☐ Joint Replacement, Knee (Right, Left, Bilateral)
- ☐ Joint Replacement, Hip (Right, Left, Bilateral)
- ☐ Joint Replacement within last 2 years
- ☐ Kidney Biopsy (Nephrectomy)
- ☐ Kidney Removed (Right, Left)
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Cyst
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Biopsy
- ☐ TURP (Prostate Removal)
- ☐ Spleen Removed
- ☐ Testicles Removed (Right, Left, Bilateral)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ NONE

Other _____

Skin Disease History
(Please check all that apply)

- ☐ Acne
- ☐ Actinic Keratoses/Precancer
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ NONE

Other _____

Do you wear Sunscreen? Yes ☐ No ☐ If yes, what SPF? _____
Do you tan in a tanning salon? Yes ☐ No ☐
Do you have a family history of Melanoma? Yes ☐ No ☐
If yes, which relative(s)? _____

History & Intake Form

Patient Name	DOB	AGE

Medications
(Please enter all current medications)

Medication	Dose (strength, frequency)	Medication	Dose (strength, frequency)
1.		4.	
2.		5.	
3.		6.	

Allergies
(Please list all allergies and reactions)

Social History
(Please check all that apply)

- ☐ Currently Smokes (frequency)_____
- ☐ Has never smoked
- ☐ Has smoked in the past
- ☐ Drug use

Family History
(Please list any malignancies or dermatology related conditions that run in your first degree relatives)

Review of Systems
(Are you currently experiencing any of the following? Please check all that apply)

- ☐ Problems with bleeding
- ☐ Problems with healing
- ☐ Problems with scarring
- ☐ Immunosuppression
- ☐ Changing mole
- ☐ Rash
- ☐ Abdominal pain
- ☐ Anxiety
- ☐ Bloody stool
- ☐ Bloody urine
- ☐ Blurry vision
- ☐ Chest pain
- ☐ Cough
- ☐ Depression
- ☐ Fever or chills
- ☐ Headaches
- ☐ Hay Fever
- ☐ Joint aches
- ☐ Muscle weakness
- ☐ Neck stiffness
- ☐ Night sweats
- ☐ Seizures
- ☐ Shortness of breath
- ☐ Sore throat
- ☐ Thyroid problems
- ☐ Unintentional weight loss
- ☐ Wheezing

Alerts

- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Artificial joints within past 2 years
- ☐ Artificial heart valve
- ☐ Premedication prior to procedure
- ☐ Allergy to adhesive
- ☐ Allergy to topical antibiotic ointments
- ☐ Allergy to oral antibiotics
- ☐ Blood thinners
- ☐ Pregnancy or planning a pregnancy
- ☐ Allergy to lidocaine
- ☐ Rapid heart beat with epinephrine
- ☐ MRSA
- ☐ Yeast infection with antibiotics
- ☐ GI upset with antibiotics
- ☐ Other:

Reason for seeing the physician today?

Signature _____ Print Name_____ Date _____

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Notice of Privacy Practices and Patient Financial & Cancellation Policies

Full Name _____

Date of Birth ____/____/____ Date ____/____/____

Thank you for choosing Dermatology & Skin Surgery Specialist for your dermatology needs. Please read the following policies and complete the sections below. Please contact a practice administrator if you have any questions.

NOTICE OF PRIVACY PRACTICES: We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to our client services staff to acknowledge that you have been provided a copy of our notice.

FINANCIAL POLICY: Dermatology & Skin Surgery Specialists has contracts with many insurance plans. Please verify with your insurance company to determine whether we participate with your specific insurance carrier. If we contract with your plan, we will file a claim (for non-cosmetic services) to your insurance company. You will be responsible for any co-pays, deductibles, purchased products, and/or non-covered service. If you do not have one of the plans with which the practice is contracted, the total cost of your visit is required at the time of your service.

- Biopsy/pathology or lab samples may be sent to labs outside of our office. These services will be billed on a separate invoice from the lab, and it will be your responsibility to pay directly to them. This is in addition to our charges.
- If you require referral authorization from your Primary Care Provider (PCP) in order for your visit with us to be covered. It is your responsibility to obtain this information and bring it to your appointment.
- It is your responsibility to provide Dermatology & Skin Surgery Specialists with your current insurance information. Failure to do so many result in charges being billed directly to you.
- Any service that is not covered by your insurance company, for whatever reason, is your financial responsibility. Any outstanding balances over 90 days will be referred to an outside collection agency. Any balance assigned to a collection agency will be assessed a 30-40% collection fee as permitted by per state law.
- All cosmetic and laser services must be paid at the time of service.

CANCELLATION POLICY:

- MEDICAL PATIENTS: Please be advised that we require at least 24 hours' notice to cancel or reschedule a medical appointment. A $30 fee will be assessed to your account with a cancellation or reschedule of less than 24 hours' notice.
- COSMETIC PATIENT: Please be advised that we require at least 24 hours' notice to cancel or reschedule a cosmetic appointment. A $50 fee per 15 minutes of appointment will be assessed to your account with a cancellation or reschedule of less than 24 hours' notice.
- SURGICAL PATIENTS: Please be advised that we require at least 48 hours' notice to cancel or reschedule a surgical appointment. A $200 fee will be assessed to your account with a cancellation or reschedule of less than 48 hours' notice.
- LATE ARRIVAL: If you arrive 15 minutes or more after your scheduled visit time, we reserve the right to reschedule your appointment.

AUTHORIZATION AND ACKNOWLEDGEMENT:

- I certify that I have been provided the Notice of Privacy Practices and the Patient Financial & Cancellation Policies.
- I have read and accept the policies of Dermatology & Skin Surgery Specialists.
- I authorize payment of medical benefits to the named provider for professional services rendered.
- I authorize release of any medical information necessary to process any claims filed.

_____ Date ____/____/____

Signature of Patient (or Legal Representative)