



DERMATOLOGY &
SKIN SURGERY
SPECIALISTS

Dermatology & Skin Surgery Specialists
8415 N Pima Road, Suite 212
Scottsdale, AZ 85258
(480) 434-6600
Fax (480) 428-8615
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 complete 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 you 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



Dermatology & Skin Surgery Specialists

8415 N Pima Rd, Suite 212
Scottsdale, AZ 85258
(480) 434-6600
Fax (480) 522-3528

Patient Information					
PATIENT NAME: LAST FIRST M.I			SOCIAL SECURITY NUMBER		
MAILING ADDRESS STREET OR PO BOX APT		DATE OF BIRTH		GENDER	
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			ETHNICITY: 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? SELECT: HOME CELL				YES NO	
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		
<p>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.</p>					
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)			
<input type="checkbox"/> Anxiety <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Bone Marrow Transplantation <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Colon Cancer <input type="checkbox"/> COPD <input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> GERD <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Hepatitis <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Hyperthyroid <input type="checkbox"/> Hypothyroid <input type="checkbox"/> Leukemia <input type="checkbox"/> Lung Cancer <input type="checkbox"/> Lymphoma <input type="checkbox"/> Prostate Cancer <input type="checkbox"/> Radiation Treatment <input type="checkbox"/> Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> None	
Other _____			
Past Surgical History (Please check all that apply)			
<input type="checkbox"/> Appendix Removed <input type="checkbox"/> Bladder Removed <input type="checkbox"/> Mastectomy (Right, Left, Bilateral) <input type="checkbox"/> Lumpectomy (Right, Left, Bilateral) <input type="checkbox"/> Breast Biopsy (Right, Left, Bilateral) <input type="checkbox"/> Breast Reduction <input type="checkbox"/> Breast Implants <input type="checkbox"/> Colectomy: Colon Cancer Resection <input type="checkbox"/> Colectomy: Diverticulitis <input type="checkbox"/> Colectomy: IBD <input type="checkbox"/> Gallbladder Removed <input type="checkbox"/> Coronary Artery Bypass <input type="checkbox"/> Mechanical Valve Replacement <input type="checkbox"/> Biological Valve Replacement <input type="checkbox"/> Heart Transplant <input type="checkbox"/> Joint Replacement, Knee (Right, Left, Bilateral) <input type="checkbox"/> Joint Replacement, Hip (Right, Left, Bilateral)	<input type="checkbox"/> Joint Replacement within last 2 years <input type="checkbox"/> Kidney Biopsy (Nephrectomy) <input type="checkbox"/> Kidney Removed (Right, Left) <input type="checkbox"/> Kidney Stone Removal <input type="checkbox"/> Kidney Transplant <input type="checkbox"/> Ovaries Removed: Endometriosis <input type="checkbox"/> Ovaries Removed: Cyst <input type="checkbox"/> Ovaries Removed: Ovarian Cancer <input type="checkbox"/> Prostate Removed: Prostate Cancer <input type="checkbox"/> Prostate Biopsy <input type="checkbox"/> TURP (Prostate Removal) <input type="checkbox"/> Spleen Removed <input type="checkbox"/> Testicles Removed (Right, Left, Bilateral) <input type="checkbox"/> Hysterectomy: Fibroids <input type="checkbox"/> Hysterectomy: Uterine Cancer <input type="checkbox"/> NONE		
Other _____			
Skin Disease History (Please check all that apply)			
<input type="checkbox"/> Acne <input type="checkbox"/> Actinic Keratoses/Precancer <input type="checkbox"/> Asthma <input type="checkbox"/> Basal Cell Skin Cancer <input type="checkbox"/> Blistering Sunburns	<input type="checkbox"/> Dry Skin <input type="checkbox"/> Eczema <input type="checkbox"/> Flaking or Itchy Scalp <input type="checkbox"/> Hay Fever/Allergies <input type="checkbox"/> Melanoma	<input type="checkbox"/> Poison Ivy <input type="checkbox"/> Precancerous Moles <input type="checkbox"/> Psoriasis <input type="checkbox"/> Squamous Cell Skin Cancer <input type="checkbox"/> 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)		
<input type="checkbox"/> Currently Smokes (frequency) _____		<input type="checkbox"/> Has never smoked
<input type="checkbox"/> Has smoked in the past		<input type="checkbox"/> 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)		
<input type="checkbox"/> Problems with bleeding	<input type="checkbox"/> Bloody urine	<input type="checkbox"/> Muscle weakness
<input type="checkbox"/> Problems with healing	<input type="checkbox"/> Blurry vision	<input type="checkbox"/> Neck stiffness
<input type="checkbox"/> Problems with scarring	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Night sweats
<input type="checkbox"/> Immunosuppression	<input type="checkbox"/> Cough	<input type="checkbox"/> Seizures
<input type="checkbox"/> Changing mole	<input type="checkbox"/> Depression	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Rash	<input type="checkbox"/> Fever or chills	<input type="checkbox"/> Sore throat
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Headaches	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Unintentional weight loss
<input type="checkbox"/> Bloody stool	<input type="checkbox"/> Joint aches	<input type="checkbox"/> Wheezing
Alerts		
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Blood thinners	
<input type="checkbox"/> Defibrillator	<input type="checkbox"/> Pregnancy or planning a pregnancy	
<input type="checkbox"/> Artificial joints within past 2 years	<input type="checkbox"/> Allergy to lidocaine	
<input type="checkbox"/> Artificial heart valve	<input type="checkbox"/> Rapid heart beat with epinephrine	
<input type="checkbox"/> Premedication prior to procedure	<input type="checkbox"/> MRSA	
<input type="checkbox"/> Allergy to adhesive	<input type="checkbox"/> Yeast infection with antibiotics	
<input type="checkbox"/> Allergy to topical antibiotic ointments	<input type="checkbox"/> GI upset with antibiotics	
<input type="checkbox"/> Allergy to oral antibiotics	<input type="checkbox"/> Other:	

Reason for seeing the physician today?

Signature _____ Print Name _____ Date _____



**DERMATOLOGY &
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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 with 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 may 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 state law.
- All cosmetic and laser services must be paid for in full at the time of service.
- All cosmetic and laser appointments require a non-refundable deposit. Appointments may be rescheduled up to 48 hours in advance. Deposit may be extended for up to three months after the originally scheduled appointment date.
- All cosmetic packages expire within a year of purchase, unless noted otherwise.
- Any unpaid no show fees must be paid prior to cosmetic package completion.

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 48 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 48 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 rescheduling 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 the release of any medical information necessary to process any claims filed.

Signature of Patient (or Legal Representative)

Date ____/____/____