TUCSON DERMATOLOGY, LTD.

Patient Information:

Date: _____ **DOB:** _____ **Language:** _____
Gender: _____Male_____Female_____Non-Binary_____Self-Described
Marital Status: ____Single____Married____Divorced____Widowed
Race: ____African American____Caucasian____Hispanic____Asian____Other: _____
SSN: _____ **Preferred Phone:** _____ **Alt Phone:** _____
Email Address: _____

Insurance Information

Primary Insurance Carrier: _____
Policy Holder Name: _____ **Relationship to Patient:** _____
Policy Holder Employer: _____ **Occupation:** _____
DOB: _____ **GROUP #:** _____ **INS I.D. #:** _____
Policy Holder SSN: _____

Secondary Insurance Carrier: _____
Policy Holder Name: _____ **Relationship to Patient:** _____
DOB: _____ **GROUP #:** _____ **INS I.D. #:** _____
Policy Holder SSN: _____

Emergency Contact Information

Emergency Contact Name: _____ **Phone:** _____
Referring Physician: _____ **Phone:** _____

How Did You Hear About Us?
____Newspaper ____ Physician ____Mailer/Postcard ____Phonebook ____Internet ____Friend
____Other: _____

I certify that all information provided above is accurate to the best of my knowledge. I authorize Tucson Dermatology, LTD to release medical information needed for insurance processing and/or to another medical provider for continuity of care purposes. I further authorize insurance benefits to be paid directly to Tucson Dermatology, LTD. I agree to pay all fees incurred and/or not covered by insurance benefits paid to Tucson Dermatology, LTD. I am aware that payment for the charge incurred is MY responsibility if my carrier denies the claim for reasons beyond Tucson Dermatology's, LTD control. I am aware that payment is expected at time of service for all patients not covered by insurance carriers with whom we are contracted. If I cannot pay in full, I am aware that special arrangements MUST be made in advance. I am aware that insurance plans do not cover cosmetic services. Cosmetic care, products, and supplies must be paid at time of the visit. I acknowledge that I have the right to read and review an extended payment policy before signing this consent and at any time during office hours. **Regarding email communications, I consent to receiving limited email communications from Tucson Dermatology, LTD and understand that all email messages are sent over the Internet and are not encrypted; therefore, there is the potential that emails may be accessed by others. Limited communications include, but are not limited to, appointment confirmations, acknowledgments, requests to contact the office, and promotional events and offers. No lab results or personal health information will be disclosed via telephone or email.*

Signature _____ Date _____/_____/_____