WELCOME TO ARIZONA DESERT DERMATOLOGY

PATIENT INFORMATION (Please Print)

NAME: Last	First	M.I	AKA (NICKNAME):

DATE OF BIRTH:	GENDER: M / F	SSN:	MARITAL STATUS:	PREFERRED LANGUAGE:

MAILING ADDRESS:	CITY:	STATE:	ZIP:

WINTER/SUMMER ADDRESS: (if different from above)	CITY:	STATE:	ZIP:

HOME PHONE:	CELL PHONE:	WORK PHONE:

EMAIL:

RACE:

American Indian	Black/African American	White
Asian	Multiracial	Decline to answer
Hispanic/Latino	Hawaiian/Pacific Islander	Alaskan Native

ETHNICITY:

Hispanic/Latino
Non-Hispanic/Latino
Unknown

Do You Have a Primary Care Provider: YES / NO	**IF YES, PCP NAME:**

INSURANCE INFORMATION

Primary Insurance Name:	Policy #:
Name of Insured:	Group #:
Birthdate of Insured:	Relation to Patient:
Is Insurance Provided By Employer: Y / N	Name of Employer:

Secondary Insurance Name:	Policy #:
Name of Insured:	Group #:
Birthdate of Insured:	Relation to Patient:
Is Insurance Provided By Employer: Y / N	Name of Employer:

Do you have a Medical Proxy:	YES / NO	Name:	Phone:
Do you have a Power of Attorney:	YES / NO	Name:	Phone:
Do you have a Living Will:	YES / NO	Name:	Phone:

I Authorize Arizona Desert Dermatology to discuss my medical records with the following individual(s):	
Name:	Phone:
Name:	Phone:
EMERGENCY CONTACT:	**PHONE:**

Patient Signature Authorizing Release:

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NAME: _____ DOB: _____

REVIEW OF SYSTEMS		
CURRENT SYMPTOMS	**YES**	**NO**
RASH		
PROBLEMS WITH BLEEDING		
PROBLEMS WITH HEALING		
PROBLEMS WITH SCARRING (HYPERTROPHIC/KELOID)		
IMMUNOSUPRESION		
THYROID PROBLEMS		
CHEST PAIN		
ANXIETY		
FEVER OR CHILLS		
NIGHT SWEATS		
UNINTENTIONAL WEIGHT LOSS		
SORE THROAT		
BLURRY VISION		
ABDOMINAL PAIN		
BLOODY STOOL		
BLOODY URINE		
JOINT ACHES		
MUSCLE WEAKNESS		
NECK STIFFNESS		
HEADACHES		
SEIZURES		
COUGH		
SHORTNESS OF BREATH		
WHEEZING		
DEPRESSION		
HAY FEVER		
PACEMAKER		
DEFIBRILLATOR		

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Name: _____ **Date of birth:** _____

History and Intake Form

	✓		✓		✓
Anxiety		Epilepsy		Malignant Tumor of Breast	
Arthritis		GERD		Malignant Tumor of Colon	
Asthma		Hepatitis A,B,C		Malignant Tumor of Lung	
Atrial Fibrillation		Hypertension		Malignant Tumor of Prostrate	
BPH		Hearing Loss		Radiation Treatment	
Cerebrovascular Accident		HIV/AIDS		Transplant of Bone Marrow	
COPD		Hypercholesterolemia		Seizures	
Coronary Artery Disease		Hyperthyroidism		Stroke	
Depression		Hypothyroidism		Valve Replacement	
Diabetes		Inflammatory Liver Disease			
Elevated Blood Pressure		Leukemia			
End-Stage Renal Disease		Malignant Lymphoma		**NONE**	
OTHER:					

List Surgeries: _____

_____

_____

Skin Disease History					
	✓		✓		✓
Acne		Eczema		Psoriasis	
Asteatosis Cutis (dry skin)		H/O: Asthma		Squamous Cell Carcinoma	
Actinic Keratosis		H/O: Hay Fever			
Basal Cell Carcinoma		Malignant Melanoma			
Dysplastic Nevus		Pruritis of Scalp (itchy scalp)		**NONE**	
OTHER:					

	Yes	No
Do you wear sunscreen?		
Do you go tan in a tanning salon?		

	Yes	No
Do you have a family history of Melanoma?		
If YES, which relative(s)?		

	Yes	No
Have you ever received the COVID-19 vaccine?		
If yes, what was the date of your most recent COVID booster?		

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Name: _____ **Date of birth:** _____

Medications (or Attach List)

Medication	Strength	Dosage	Frequency

Drug Allergies:

_____

_____

Social History (Please Circle all that apply)

What is your smoking status?

Never used tobacco

Quit: Former tobacco user

Uses tobacco less than daily

Uses tobacco daily

Height: _____

Weight: _____

Do you consume alcohol?

None

Less than one drink per day

1-2 drinks per day

3 or more drinks per day

Are you pregnant? _____

Are you breast feeding? _____

How many times in the past year have you had 4 or more drinks in one day? _____

Do you use recreational drugs?

None

Drug Use

IV Drug Use

Reason for Today's Visit:

_____

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ATTENTION PATIENTS

By supplying my phone number and email address, I authorize my health care provider to use a third-party automated messaging system to use my information, the name of my provider, the time and place of my scheduled appointment(s), and other limited information for the purpose of notifying me. This includes notification of a pending appointment, a missed appointment, balances due, or any other healthcare related function. I authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare visits. I consent to receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

HOW WOULD YOU LIKE TO BE CONTACTED?

Emails go out FIVE days prior to appointment, phone calls go out THREE days prior to appointment, and text messages go out TWO days prior to appointment
(Please provide number or email)

EMAIL:	
PHONE:	
TEXT:	
Would you like all three? Yes or No	

PATIENT SIGNATURE: **DATE:**

PHARMACY INFORMATION:

I allow Arizona Desert Dermatology permission to view my prescription history from external sources (my pharmacies).

I use the following pharmacy/pharmacies:

NAME OF PHARMACIES:

PATIENT SIGNATURE: **DATE:**

WELCOME TO ARIZONA DESERT DERMATOLOGY

- I acknowledge full financial responsibility for medical services rendered and I agree to pay in full at the time of service, or to make prior arrangements for payment. If my account is placed for collections, I acknowledge responsibly for associated collection expenses. A fee, determined by our collection agency, will be added to any balance turned over to collections. There will be a charge for canceled or broken appointments without 24-hour notice as follows: $20 Established, $40 New, $50 Cosmetic, and $100 for all surgery and MOHS appointments. There will be a $35 charge for all Returned checks.
- We will bill your insurance as a courtesy to you. We will wait 60 days to remit payment. If it is not paid within this time, the bill becomes due and payable in full by the person responsible for payment of this account. We suggest you work closely with your insurance to expedite payment. It is your responsibility to provide them with information requested. Please forward any information they request.
- A written copy of the Privacy practices for Arizona Desert Dermatology has been made available to me.
- I authorize you to take photographs of my medical condition to be used for educational purposes.
- I authorize Arizona Desert Dermatology to release my medical records to the doctor who referred me and to a doctor I am referred to. I further authorize the release of any information to my insurance company necessary for processing my claims.
- I request that the payment of benefits be made on my behalf to Arizona Desert Dermatology for the services provided to me by their providers.

Patient Signature:	**Date:**

Get to know your insurance

INSURANCE CONTRACTS:	NETWORK CONTRACTS:
Aetna	Accountable Health
Blue Cross Blue Shield	Aetna
GEHA	AZ Foundation for Medical Care
Humana (Medicare Replacement)	Beech Street
Medicare & Medicare Railroad	Blue Cross Blue Shield
Phoenix Health & Life (Medicare Replacement)	First Health
Sierra Health & Life	Health Smart
Tricare	HMA/HMN
United Healthcare (NOT ALL POLICIES)	Intragroup
	Managed Care Consultants
	MultiPlan
NOT ALL PLANS AND CONTRACTS LISTED	PHCS

Contracted Insurances: Co-pays are usually applied to the office visit charge. Some Insurances apply procedures done at the same visit to the in-network deductible, co-insurance or another co-pay.
Non-Contracted Networks: Charges are usually applied to your out of network deductible and co-insurance; however, you receive a network discount.
Insurance companies have their own rules and guidelines independently, if you are unsure how your insurance will process your claims, please contact your representative for clarification. **Our office does not guarantee nor take responsibility for how your insurance company processes your claims.**

Patient Signature:	**Date:**

Medicare Patients Only

Provider's name: Arizona Desert Dermatology

I request that payment under the medical insurance program be made either to me or to the provider named above on any bills for service furnished to me during the effective period of this authorization and I authorize the above named provider to release to the Social Security Administration or it's intermediaries or carries any information needed for this claim or any related Medicare Claim. I further permit a copy of this authorization to be used in place.

Patient Signature:	**Date:**

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I,_____ _____ herein request and authorize

(Patient Name) (Date of Birth)

Arizona Desert Dermatology & Surgery, P.C to **forward** a copy or summary of the following records **to my Primary Care Provider.**

✓

	Complete Medical Records
	Biopsy Report(s)
	Lab Report(s)
	Consultation Reports
	Medication Allergies
	Surgical Procedure(s)

TO:

_____

DOCTOR OR FACILITY (PRIMARY CARE PHYSICIAN)

_____

ADDRESS

_____ _____

PHONE **FAX**

PATIENT SIGNATURE:	**DATE:**

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Payment Policy

A Payment policy lets our patients know what we expect of them and what they can expect of us. We believe a well-crafted policy will prevent patients from being surprised about their financial obligation when they receive services. It will also give our practice some legal protection should a patient fail to pay what we are entitled to collect.

- Payment is due on the day of service, unless other arrangements have been made in advance.
- Self-pay patients are responsible for the entire amount billed for that day of service.
- Patients who have medical insurance are responsible for any amount not covered by their insurance.
- If the patient's insurance company pays directly to the patient, the entire balance is due on the date of service. (i.e. BCBS Fed – we bill insurance on request only)
- Deductibles and copays are collected at each visit.
- Forms of payment accepted: personal checks, debit cards, credit cards, cash, and care credit.
- We enlist a collection agency's help after three months of non-payment.

Medical Insurance

Two common mistakes regarding medical insurance:

1. Thinking that your insurance company is responsible for paying your medical bills.
2. Thinking that your medical providers are required to bill your insurance company.

The truth is consumers are responsible for their own medical debts. Meaning the consumers must ensure that their insurance company is billed in a timely manner and that it is being billed correctly.
As a convenience for you, most medical providers will offer to bill your insurance company. Accepting their offer doesn't relieve you of the responsibility of ensuring that the bill gets paid. The bottom line is that the consumer is still responsible for paying any medical debt. In some cases, your insurance company will reject a bill or refuse to pay the bill, if this happens the provider will expect you to pay the bill. Unless you have disputed the debt, you are legally expected to pay the bill in a timely manner. You may have to argue with your insurance company or go through dispute resolution, but the provider is entitled to a timely payment. You may have to pay the provider yourself and then work with your insurance company to get reimbursed.

Patient Signature: _____ Date: _____