VALLEY SKIN CANCER SURGERY

Dermatologic and Mohs Micrographic Surgery

PATIENT INFORMATION RECORD

Please Use Black Ink Only

Patient Information

Patient's Name____
Last First Middle Initial

Address_______________________City______________State_______Zip________

Date of Birth_______________ Age______ Social Security #__________________

Home Phone: (_____) ________________________

☐ O.K. to leave message with detailed information (Extended) ☐ Leave message with call-back number only (Brief)

Cell Phone: (_____) ____________________________

☐ O.K. to leave message with detailed information (Extended) ☐ Leave message with call-back number only (Brief)

Work Phone: (_____) _________________________

☐ O.K. to leave message with detailed information (Extended) ☐ Leave message with call-back number only (Brief)

Email Address___________________________________ Sex: ☐ Female ☐ Male
(For access to our Patient Portal)

Emergency Contact______________________________ Phone #__________________

Relationship to Patient: _____________________________________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Employer_________________________________ If Student: ☐ Full Time ☐ Part Time

Referring Doctor______________________________ Phone #__________________

In order for our healthcare practice to meet the qualification requirements under the American Recovery and Reinvestment Act of 2009, we are required to obtain the following information:

Race: ☐ American Indian or Alaska Native ☐ Black or African American
☐ Asian ☐ White ☐ Other Race
☐ Native Hawaiian or Other Pacific Island ☐ Hispanic ☐ Refuse to Report

Ethnicity: ☐ Hispanic or Latin ☐ Non-Hispanic ☐ Refuse to Report

Language: ☐ English ☐ Spanish ☐ French ☐ Japanese ☐ Chinese ☐ Other

Insurance Information

Primary Insurance_____________________________ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Policyholder's Name______________________________ ☐ Other _______________

Date of Birth _____________ Phone_____________________ Social Security#_________________

If different from patient:
Address___________________________________City________________State__________Zip__________

Employer ____ Phone # _________________________________

Secondary Insurance____________________________ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Policyholder's Name_______________________________ ☐ Other _______________

Date of Birth _____________ Phone_____________________ Social Security#_________________

If different from patient:
Address___________________________________City________________State__________Zip__________

Employer ____ Phone # _________________________________

If the responsible party is someone *OTHER THAN* ***the*** *PATIENT* ***or the*** *POLICYHOLDER*

Name____
Last First Middle Initial

Address________________________________ City________________ State_______ Zip_______________

Primary Phone # ______________________________ Secondary Phone # ____________________________

Date of Birth ______________________ Email Address ____

Employer _______________________________________ Phone # _________________________________

Power of Attorney

If, during my status as a patient at East Valley Dermatology & Valley Skin Cancer Surgery, I become incapacitated, I have a Medical Power of Attorney to provide for my records: ☐ Yes ☐ No

Power of Attorney Name: ______________________________ Phone #: ___________________________

Pharmacy Information

Local Pharmacy Name: ________________ Cross Streets: __________________________ City: __________

Mail Order Pharmacy Name: ______________________________________

AUTHORIZATION TO VIEW PRESCRIPTION HISTORY FROM EXTERNAL SOURCE

I authorize East Valley Dermatology Center & Valley Skin Cancer Surgery to view any and all available Prescription History from an External Source. I am aware that East Valley Dermatology Center & Valley Skin Cancer Surgery uses a secure connection to SureScripts to send and receive most prescriptions in the office.

____ __________________________
(Signature of Patient or Responsible Party) (Date)

____
(Relationship to Patient)

Authorization to Release Information, Assignment of Benefits and Notice of Privacy Practices:

I authorize the release of any/all information regarding my diagnosis and treatment to the following person(s) below, until I notify you otherwise:

Name(s): 1. _________________________ 2. _________________________ 3. _______________________

By signing this, I authorize payments of medical benefits to the provider for services rendered or to be rendered in the future, without obtaining my signature on each claim submitted. My signature will bind me as though I personally signed the claim. I also authorize the release of any medical information necessary. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES. If this account should be referred to a collection agency, I will be responsible for a $20.00 service fee on any unpaid balance.

I acknowledge that I have received The Notice of Privacy Practices.

Understanding Health Insurance Benefits

Co-Pay: This is the amount that you will be expected to pay upon check-in for each appointment. Specialist Co-payments may be higher than what you would normally pay for your PCP visits. Please be prepared to pay by Visa, MasterCard, Discover, Cash or Check at the time of service.

Deductible: This is an amount designated by your plan that you will pay for covered services each calendar year before your insurance plan begins to pay benefits for certain covered services. If you have a surgical deductible, then procedures such as biopsies, freezing's, wart treatments etc. may be applied towards your surgical deductible.

Co-Insurance: This is the percentage of the visit or procedure that you will be responsible for. If you have a deductible in addition to co-insurance, your deductible must first be met before your insurance will begin to pay.

Once your insurance carrier has processed your claim, you will receive an invoice for any remaining patient responsibility. If you have any questions regarding your benefits, we recommend that you contact your insurance carrier directly to receive your specific coverage details.

Dermatology does NOT fall under Preventive/Well Visit coverage.
Patients will be responsible for Co-Pay/Deductible/Co-Insurance.

Must be 18 years or older to sign this authorization:

Patient's Name (*print*) ____

Responsible Party Signature ____ Date _________________

VALLEY SKIN CANCER SURGERY
1100 S. Dobson Road Suite 223
Chandler, AZ 85286
Phone 480-214-0388 Fax 480-821-0888
www.vscsaz.com