

**Patient Registration Sheet** (please print in **black pen** and fill out completely) (list "N/A" if not applicable)

Legal Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Sex M / F Marital Status S / M / D / W

Phone – Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Preferred Pharmacy/Phone \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Spouse's Employer \_\_\_\_\_ Phone \_\_\_\_\_

Nearest Relative (or Friend) Not Living with Patient \_\_\_\_\_

Relationship \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

**Check here if you have a health care power of attorney (a copy of the document must be attached)**

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**Sent by:**  Doctor Name \_\_\_\_\_ / Specialty \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

Friend / Family Name \_\_\_\_\_

Other (How did you hear about us?) \_\_\_\_\_

**Please list other family members who are patients here** \_\_\_\_\_

**Primary Care Physician** (if as above, check here \_\_\_\_)

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

**Employment Information:**

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer City, State, Zip \_\_\_\_\_

Employer Phone Number \_\_\_\_\_

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I authorize Dr. Huether or his office staff to discuss my health condition with the following individuals:

**(MUST LIST THE NAMES OF FAMILY OR FRIENDS):** \_\_\_\_\_

Other than phone messages which may be left for appointment reminders, check below if appropriate:

**I DO NOT AUTHORIZE** messages to be left on my answering machine regarding details of my medical care.

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**Insurance Information (must be completed in full in addition to providing the actual card)**

**Primary Insurance Company** \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

Policy Holder's Name & Date of Birth \_\_\_\_\_ Policy Holder's Social Security # \_\_\_\_\_

Policy Holder's Relationship to Patient \_\_\_\_\_ Copay \$ \_\_\_\_\_ Deduct \$ \_\_\_\_\_ Effective Date: \_\_\_\_\_

**Secondary Insurance Company** \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

Policy Holder's Name & Date of Birth \_\_\_\_\_ Policy Holder's Social Security # \_\_\_\_\_

Policy Holder's Relationship to Patient \_\_\_\_\_ Copay \$ \_\_\_\_\_ Deduct \$ \_\_\_\_\_ Effective Date: \_\_\_\_\_

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I authorize the release of medical information which could include HIV status, communicable disease, drug abuse information or pathologic slides/reports to and from my primary care and referring physician(s), outside laboratories or consultants, if needed, in the course of my examination and treatment and as necessary to process insurance claims, insurance applications and prescriptions until revoked in writing. I also authorize payment of medical benefits to the physician and Arizona Skin Cancer Surgery Center, P.C. I am aware that the **Notice of Privacy Practices** and **Patient Rights and Responsibilities** are available to me for review at anytime.

Patient or Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_