

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 _____ - _____ (9 digit zip code required) Sex M / F Marital Status S / M / D / W

Phone - Home () _____ Work () _____ Cell () _____

E-Mail Address: _____

***If you have an alternative address/phone, list here: _____

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 _____

Do you have a health care power of attorney? YES NO Are you are currently a hospice patient? YES NO

I AUTHORIZE Dr. Huether or his office staff to discuss my health condition with the following individuals: (MUST LIST THE NAMES OF SPOUSE, FAMILY OR FRIENDS THAT WE CAN SPEAK WITH): _____

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.

Sent by: Doctor PA NP Name _____ / Specialty _____

Address _____ / Phone Number _____

City, State, Zip _____

Friend / Family Name _____

Other (How did you hear about us?) _____

Please list other family members who are patients here _____ AND/ OR [] I HAVE SEEN DR. HUETHER IN THE PAST

Primary Care Physician (if as above, check here ____)

Employment Information:

Name _____

Employer _____

Address _____

Employer Address _____

City, State, Zip _____

Employer City, State, Zip _____

Phone Number _____

Employer Phone Number _____

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: _____

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 the Arizona Skin Cancer Surgery Center, P.C. I have received and read the Notice of Privacy Practices, Patient Rights & Responsibilities and Advanced Directives Policy.

Patient or Responsible Party Signature

Date ____ / ____ / ____