Michael J. Huether, M.D., P.C. / Arizona Skin Cancer Surgery Center, P.C. Appointment Date _____/_____/_____
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**) 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 _____-_____-_____ **Pharmacy Name/Cross Streets/Phone_____**

Language _____ Race _____

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 Living Will? Y/N Power of Attorney? Y/N DNR? Y/N We can only honor these documents if we have a copy on file. Are you attaching a copy of these documents today? Y/N Are you currently a hospice patient? Y/N
Do you have State AHCCCS ins. or are you in the process of applying for it or being approved for it? Y/N

☐ **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 _____ Phone Number_____

☐ 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 ____)

Name _____

Phone Number_____

Employment Information:

Employer_____

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_____/_____/_____

Reviewed: _____/_____/_____ Signature: _____

_____/_____/_____ Signature: _____

_____/_____/_____ Signature: _____