Alta Dermatology Group
130 S. 63rd Street ~ Suite 114 ~ Mesa, Arizona 85206
480~981~2888

PATIENT INFORMATION FORM

Today's Date: ____/____/_____

(Print)
First Name: _____Middle: _____ Last Name: _____ Sex: ☐M ☐F ☐T

Date of Birth: _____/_____/_____ Age: _____ Social Security #: _____/____/_____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Local Address: _____ Apt/Unit/Space#: _____

City: _____ State: _____ ZIP: _____

Summer Address: _____ Apt/Unit/Space#: _____

City: _____ State: _____ ZIP: _____ Phone: (____) _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Primary Care Physician: _____ Phone: (____) _____

Would you like to have online access to your confidential medical records via the Patient Portal?
☐ YES your e-mail address: _____ ☐ NO

***Optional Questions*: (Questions asked to comply with Federal meaningful use requirements)**
***Preferred Language*: _____**

***Race*:** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐Hispanic ☐ White
☐ Native Hawaiian/Other Islander ☐ Other Race ☐ Other Pacific Islander ☐ Refuse to Report

PATIENT PRIVACY INFORMATION

- Federal law says that Alta Dermatology Group (ADG) cannot share your health information without your permission except in certain situations. By signing this form, you are giving ADG permission to share your health information that ADG has with the person(s)/entity you indicate below.
- This authorization is voluntary.
- ADG cannot promise that the person(s)/entity you permit ADG to share your health information with will not share your health information with someone else you may not want to have your health information.
- You can keep a copy of this authorization, and can contact ADG to get a copy if you don't have one.
- This authorization will expire at the end of each calendar year ***(January 1-December 31)*** and will need to be updated yearly.

❑**YES** ❑**NO** ***I give permission to (ADG) to leave my personal medical information (ie: pathology, surgery, or lab results etc.) on the answering machine of the telephone numbers I have listed or via my email address.***

❑**YES** ❑**NO** ***Is patient currently enrolled in Hospice?***

❑**YES** ❑**NO** ***Do you have a Power of Attorney to assist in your medical care decisions?***

Name of P.O.A. _____ Relationship: _____ Phone: (_____) _____
For Alta Dermatology Group use only: Make a copy of the above P.O.A. documents and enter in system.

I give permission to Alta Dermatology Group to use the names listed below as my emergency contact(s) and/or to share my health information with via telephone or in person:

Name: _____ Relationship: _____ Phone: (_____) _____

Patient Name: (print) _____ Date of Birth:_____

Additional Information:

Occupation: _____ Employer: _____ Work Phone: (____) _____Ext._____

Employer Address: _____ City, St., Zip _____

PLEASE PRESENT YOUR VALID INSURANCE CARD(S) ALONG WITH YOUR PHOTO ID; TO FILE FOR ANY BENEFITS DUE YOU AND COMPLY WITH RED FLAGS RULES AND OFFICE POLICIES.

Insurance Information:

PRIMARY INS. CO.: _____ Network: (if applicable) _____

Claims Address: _____ Phone: (_____)_____

Policy/Member #: _____ Group #: _____

Subscriber Name:_____ Relationship to insured: _____

Subscriber SS#____/___/____ Subscriber DOB: ___/___/___

SECONDARY INS. CO.: _____Network: (if applicable) _____

Claims Address: _____ Phone: (_____)_____

Policy/Member #: _____ Group #: _____

Subscriber Name:_____ Relationship to insured: _____

Subscriber SS#___/___/_____ Subscriber DOB: ___/___/_____

***A copy of the Notice of Privacy Practices* is available upon your request.**
Please check your preference.

☐ **YES** ***I would like a copy*** ☐ **NO** ***I do not want a copy***

Print name: _____ Signature: _____

If you are the Parent/Legal Guardian completing this paperwork for a patient who is *a minor*; please print and sign name below:

Print name: _____ Signature: _____