**Patient Information Form**

PINNACLE DERMATOLOGY
medical | surgical | cosmetic

☐ **New Patient**

| ACCOUNT NUMBER: |
|---|
| |

## PATIENT INFORMATION

| PATIENT NAME (LAST) | (FIRST) | (M.I.) | HOME PHONE NUMBER |
|---|---|---|---|
| ADDRESS | | | CELL PHONE NUMBER |
| CITY, STATE | ZIP | COUNTY | DOB |
| EMAIL ADDRESS | | GENDER | SOCIAL SECURITY |
| LANGUAGE | RACE | ETHNIC GROUP | PRIMARY CARE PHYSICAN |
| EMPLOYER | MARTIAL STATUS | REFERRING PHYSICAN | |
| SPOUSE NAME | | PHONE NUMBER | |
| EMERGENCY CONTACT | RELATIONSHIP TO PATIENT | PHONE NUMBER | |
| WOULD YOU LIKE TO OPT IN TO EMAIL NOTIFICATIONS? YES NO | IS IT OKAY TO LEAVE A DETAILED MESSAGE? YES NO | | |

## GUARANTOR/RESPONSIBLE BILLING PARTY INFORMATION

| GUARANTOR | D.O.B | SOCIAL SECURITY |
|---|---|---|
| BILLING ADDRESS | CITY, STATE | ZIP CODE |
| EMPLOYER | EMPLOYER PHONE | |

## INSURANCE INFORMATION (Please present your insurance cards/forms to receptionist)

| PRIMARY INSURANCE | INSURANCE HOLDER/SUBSCRIBER | D.O.B. | SSN |
|---|---|---|---|
| POLICY NUMBER | | GROUP NUMBER | |
| ADDRESS | | PHONE NUMBER | |
| SECONDARY INSURANCE | INSURANCE HOLDER/SUBSCRIBER | D.O.B. | SSN |
| POLICY NUMBER | | GROUP NUMBER | |
| ADDRESS | | PHONE NUMBER | |

I, _____ hereby authorize Prime Medical Group, PLLC dba Pinnacle Dermatology and their physicians to disclose the medical information to other physicians or healthcare providers who are treating me/my child. I understand that the information I am authorizing to be disclosed may contain references to psychiatric conditions, drug and alcohol abuse information, genetic testing information, and the results of specific laboratory tests, including HIV or AIDS diagnosis. All services rendered are the financial responsibility of the patient and not the insurance company. Our office will bill your insurance company as a courtesy. Your financial responsibility is to ensure that Prime Medical Group, PLLC dba Pinnacle Dermatology, P.A. and Arkansas Dermatopathology, PLLC is paid for services rendered. This includes liability covered injuries, as bills will not be postponed in anticipation of legal settlement. Information will be provided to you to file your insurance and supplied to your attorney upon request. I hereby authorize the doctors of Pinnacle Dermatology to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the doctor all payments for medical services rendered to my dependents or myself. I understand that this authorization will remain in effect for as long as my dependents or I remain a patient.

_____ _____

Signature of Patient or Responsible Party Date