Richard A. Cirelli, M.D., P.C.

SunWest **Dermatology and Skin Cancer Treatment Center**

PATIENT REGISTRATION FORM

How did you hear about us? Phone Book / Internet / Patient or Friend / Doctor / Facebook / Other: _____

Patient Legal Name: _____ □ Jr. □ Sr. Preferred to be called: _____

E-mail address: _____

Sex □ Male □ Female Date of Birth: _____ Social Security Number: _____

Mobile/Cell: _____ Home: _____ Work: _____

Mailing Address _____
City State Zip

Street Address (if different) _____
City State Zip

Marital Status: S / M / D / W Ethnicity: _____ Race: _____ Preferred Language: _____

Spouse's Name: _____ D.O.B.: _____

Primary Care Physician: _____ Telephone Number: _____

Emergency Contact

Name: _____ Relationship: _____ Best Contact Number: _____

May we discuss any and all medical information with the person listed above? □Yes □No
May we leave personal medical information on voicemail or answering machine(s) at telephone numbers provided? □Yes □No
Are there any other family members you give us permission to discuss your protected medical information with? □Yes □No

If yes, whom? Please list. _____

MINORS ONLY LEGAL GUARDIAN PARENT INFORMATION FOR MINORS (17 YEARS AND YOUNGER)

Legal Guardian/Responsible Parent Name: _____ Date of Birth: _____

I authorize the office of Richard A. Cirelli, MD, PC to provide medical and/or surgical care, including, but not limited to diagnostic testing and medically necessary treatments to the minor child when unaccompanied to an appointment. I understand payment is due when services are rendered and being the legal guardian/parent I am financially responsible for services rendered. By signing below, I acknowledge I have read, understand, agree and consent to the consent regarding minor child.

Legal Guardian/Parent Signature: _____ Date: _____

955 Black Drive
Prescott, Arizona 86305
Phone (928) 445-7546 Fax (928) 445-7598

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Patient Name _____ Date of Birth _____

INSURANCE INFORMATION

INSURANCE CARDS MUST BE PRESENT AT THE TIME OF YOUR APPOINTMENT WITH PHOTO ID

PRIMARY Insurance Carrier Name: _____

Policy #: _____ Group # _____

Policy Holder Name (if not patient): _____ Relationship to Policy Holder: □Spouse □Parent □Other

Date of Birth: _____ Social Security #: _____ Employer: _____

SECONDARY Insurance Carrier Name: _____

Policy #: _____ Group # _____

Policy Holder Name (if not patient): _____ Relationship to Policy Holder: □Spouse □Parent □Other

Date of Birth: _____ Social Security #: _____ Employer: _____

** The Affordable Care Act requires us to collect data consistent with standards set by the government for reporting. Please complete all requesting information. **

I authorize the release of any medical information necessary to process claims and hereby assign all benefits payable to Richard A. Cirelli, MD, PC dba SunWest Dermatology and Skin Cancer Treatment Center on my behalf for all services rendered. In the case that my insurance company reimburses me directly, I will submit payment from the insurance company directly to Richard A. Cirelli, MD, PC. I understand I am financially responsible for all charges for services rendered even in cases my insurance denies payment for services rendered. I authorize the release of my medical information to other physicians for continuity of care and/or treatment by our office or another medical office. I acknowledge that I have received, read, and understand the Financial Policy and Release of Information which has been provided to me.

Health Insurance Portability and Accountability Act (HIPAA): I understand I have certain rights regarding the privacy of my protected health information. I acknowledge that I have received and have access to a copy of the Notice of Privacy Practices. I understand the practice has the right to change its Notice of Privacy Practices and Financial Policy and Release of Information and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices or Financial Policy and Release of Information. I may also contact the practice at any time with any questions I may have or if I have a concern regarding my protected health information. I authorize a copy of this authorization may be used in place of the original. I understand it is the policy of this office to remind patients of their appointments. This may be done by telephone or e-mail.

My signature below represents the above information is accurate to the best of my knowledge. I acknowledge I have obtained, understand, have access to and agree to abide by all the practices policies. I understand that this consent shall remain in force from this time forward.

_____ _____

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE/PARENT DATE Updated 5/1/2017

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