PINNACLE DERMATOLOGY
medical | surgical | cosmetic
A Division of Prime Medical Group, PLLC

Is Patient a Minor? ☐Yes ☐No

Date of Birth

Patient Information

Legal Name Last	First	M.I.	Nickname/Preferred Name

Address	City, State	Zip	Cell Phone Number

Email Address for your Patient Portal	Work Phone Number	Home Phone Number

Preferred Method of Contact ☐Cell ☐Home ☐Work ☐Text ☐Portal	May we leave a detailed voicemail? ☐Yes ☐No

Gender ☐Male ☐Female	Race ☐Decline to Specify	Ethnic Group ☐Decline to Specify	Preferred Language (if not English)

Emergency Contact	Emergency Contact Relationship to Patient	Emergency Contact Phone Number

Guarantor / Responsible Billing Party Information

Guarantor	Guarantor Date of Birth	Guarantor Relationship to Patient

Address ☐Same as above	City, State	Zip	Phone Number

Insurance Information (please present your insurance card and ID at time of visit)

Primary Insurance Policy Carrier	Policy Number	Group Number

Policy Holder Name	Relationship to Patient	Policy Holder Date of Birth

Secondary Insurance Policy Carrier	Policy Number	Group Number

Policy Holder Name	Relationship to Patient	Policy Holder Date of Birth

Tertiary Insurance Policy Carrier	Policy Number	Group Number

Policy Holder Name	Relationship to Patient	Policy Holder Date of Birth

Authorizations and Acknowledgements

I hereby state that the above information is true and correct to the best of my knowledge. I authorize my insurance or other third-party carrier benefits to be paid directly to Prime Medical Group, PLLC for any and all medical, surgical and pathology services rendered, realizing I am responsible for any resulting balance. I also authorize Prime Medical Group and Pinnacle Dermatology, a division of Prime Medical Group, and their physicians to release any information required to process this claim to my insurance carrier. I acknowledge that I am financially responsible for services rendered, not the insurance company. Failure to pay any outstanding balances may result in collection procedures being taken. Further, I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts of mine, or to a family member whose account I am guarantor for.

I authorize Prime Medical Group, Pinnacle Dermatology, and their physicians to disclose medical information to other physicians or healthcare providers who are treating me and/or 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 diagnosis.

I understand that these authorizations will remain in effect for as long as my dependents or I remain a patient and/or have an outstanding balance.

If you are signing on behalf of the patient, please fill out the following information:

Name _____ Relationship to the Patient _____ Phone Number _____

Address _____ ☐Same as Patient

If applicable, please furnish a copy of conservatorship/guardianship papers prior to the appointment.

By signing below, I confirm that I have read, authorize, and agree to the information above.

Signature of Patient/Parent/Legal Guardian _____ Date _____