PINNACLE DERMATOLOGY
medical | surgical | cosmetic

A Division of Prime Medical Group, PLLC

# Patient Demographics Form

Patient date of birth

Is the patient a minor? ◯ Yes ◯ No

## Patient information

Legal last name | Legal first name | M.I. | Nickname or preferred name

Address | City, state | ZIP code

Cell phone number | Work phone number | Home phone number

Email address for your patient portal

Preferred method of contact (check all that apply) ☐ Cell ☐ Home ☐ Work ☐ Text ☐ Portal

May we leave a detailed voicemail? ◯ Yes ◯ No

Gender ◯ Male ◯ Female

Race | Ethnic group | Preferred language (if not English)

☐ Decline to specify ☐ Decline to specify

Emergency contact name | Relationship to patient | Phone number

## Guarantor (responsible billing party)

Guarantor name | Guarantor date of birth | Guarantor relationship to patient

Address | City, state | ZIP code | Phone number

☐ Guarantor address is the same as the patient's address

## Insurance information

Please present your insurance card and ID at the time of your visit.

### Primary insurance

Insurance policy carrier | Policy number | Group number

Policy holder name | Relationship to patient | Policy holder date of birth

## Insurance information (continued)

### Secondary insurance

Insurance policy carrier | Policy number | Group number

Policy holder name | Relationship to patient | Policy holder date of birth

### Tertiary insurance

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

Your name | Relationship to the patient | Phone number

Address

☐ Address is the same as the patient's address

*If applicable, please provide a copy of conservatorship or guardianship papers before the appointment.*

## Signature

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

Signature of patient, parent or legal guardian | Date

Questions or need help with this form? Call 501-817-3923 (TTY: 800-285-1131) or text 501-550-9095. We can provide large print, read the form aloud with you, or help you fill it out, free of charge.