

**Michael J. Huether, M.D., P.C. / Arizona Skin Cancer Surgery Center, P.C.** Appointment Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Patient Registration Sheet** (please print in **black pen** and **fill out completely**) (list "N/A" if not applicable)

Legal Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ - \_\_\_\_\_ (9 digit zip code required) Sex M / F Marital Status S / M / D / W

Phone: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

\*\*\*If you have an alternative address/phone, list here: \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Preferred Pharmacy/Phone \_\_\_\_\_

Language \_\_\_\_\_ Race \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Spouse's Employer \_\_\_\_\_ Phone \_\_\_\_\_

Nearest Relative (or Friend) Not Living with Patient \_\_\_\_\_

Relationship \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

**Do you have a Living Will? Y/N Power of Attorney? Y/N DNR? Y/N We can only honor these documents if we have a copy on file. Are you attaching a copy of these documents today? Y/N Are you currently a hospice patient? Y/N Do you have State AHCCCS ins. or are you in the process of applying for it or being approved for it? Y/N**

I **AUTHORIZE** Dr. Huether or his office staff to discuss my health condition with the following individuals (MUST LIST THE NAMES OF SPOUSE, FAMILY OR FRIENDS THAT WE CAN SPEAK WITH): \_\_\_\_\_

Other than phone messages which may be left for appointment reminders, check below if appropriate:

I **DO NOT** AUTHORIZE messages to be left on my answering machine regarding details of my medical care.

**Sent by:**  Doctor  PA  NP Name \_\_\_\_\_ / Specialty \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_ Phone Number \_\_\_\_\_

Friend / Family Name \_\_\_\_\_

Other (How did you hear about us?) \_\_\_\_\_

**Please list other family members who are patients here \_\_\_\_\_ AND/ OR [ ] I HAVE SEEN DR. HUETHER IN THE PAST**

**Primary Care Physician** (if as above, check here \_\_\_\_)

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

**Employment Information:**

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer City, State, Zip \_\_\_\_\_

Employer Phone Number \_\_\_\_\_

**Insurance Information (must be completed in full in addition to providing the actual card)**

**Primary Insurance Company** \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

Policy Holder's Name & Date of Birth \_\_\_\_\_ Policy Holder's Social Security # \_\_\_\_\_

Policy Holder's Relationship to Patient \_\_\_\_\_ Copay \$ \_\_\_\_\_ Deduct \$ \_\_\_\_\_ Effective Date: \_\_\_\_\_

**Secondary Insurance Company** \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

Policy Holder's Name & Date of Birth \_\_\_\_\_ Policy Holder's Social Security # \_\_\_\_\_

Policy Holder's Relationship to Patient \_\_\_\_\_ Copay \$ \_\_\_\_\_ Deduct \$ \_\_\_\_\_ Effective Date: \_\_\_\_\_

I authorize the release of medical information which could include HIV status, communicable disease, drug abuse information or pathologic slides/reports to and from my primary care and referring physician(s), outside laboratories or consultants, if needed, in the course of my examination and treatment and as necessary to process insurance claims, insurance applications and prescriptions until revoked in writing. I also authorize payment of medical benefits to the physician and the Arizona Skin Cancer Surgery Center, P.C. I have received and read the **Notice of Privacy Practices, Patient Rights & Responsibilities and Advanced Directives Policy.**  
**Patient or Responsible Party Signature** \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_