Patient Information Please Complete Entire Form

Filling in all spaces is important for your own protection and to help ensure your insurance is billed correctly.

Date ____________

Last Name ___________________________________First ________________________ Middle ________________

Preferred Name/Nickname ____ Sex: M ___ F ___

Social Security # __________________________Birth Date ______________ Marital Status: M___ D___ W___ S___

Address ____ _____ Apt ______

City ____State ____ Zip _________

Home & Cell Phone # (H)____________________(C)_____________________OK to leave message? Yes ___ No ___

Cell Phone Provider (Verizon, ATT, etc.) if you want us to "text" your appointment information): ____________________

Work Phone Number ____OK to leave message? Yes___ No ___

e-mail address ____OK to send message? Yes ___ No___

Name of Primary Care or Referring Physician: Dr. ____

Patient Employer Information

Patient's Employer ____Retired_____ Student ___

Employer Address ____City ________________State ___ Zip ______

Insurance Information (ALL BLANKS MUST BE FILLED IN TO HELP ENSURE YOU ARE NOT BILLED FOR ITEMS YOUR INSURANCE SHOULD COVER)

Do you have health insurance? Yes ___ No___ **(If you do not have Health Insurance, or if your procedure is not covered by your insurance, you will be responsible for payment of all fees upon time of service)**

Primary Insurance Company Name ____

Policy Holder for the Primary Insurance: Self___ Spouse___ Parent ___ Other________________________________

Plan ID # _______________________________________ Group ID # ____________________________________

Policy Holder Name _____________________________________ DOB ____________ SSN __________________

Policy Holder Address ________________________________ City __________________ State ___ Zip __________

Employer _______________________________________ Employer Phone # _______________________________

CONTINUED ON NEXT PAGE

Secondary Insurance Company Name ____

Policyholder for the Primary Insurance: Self___ Spouse___ Parent___ Other____________________

Plan ID # ______________________ Group ID # ______________________

Policy Holder Name _________________________ SS#_________________DOB __________

Policy Holder Address: ____

Employer ______________________________ Employer Phone # ______________________

Spouse or Parent's Information --- If patient is covered by spouse or parent insurance

Spouse/Parent's Name ____________________________Spouse/Parent's DOB _______________

Spouse / Parent's SSN __________________________ Employer's Phone __________________

Spouse / Parent's Employer's Address City _______________________________State ___ Zip _______

Emergency Contact Information

Name ____________________________

Phone(s) __________________________

Relationship to Patient ______________

Preferred Pharmacy

Name _________________________________

Location _______________________________

Phone________________ Fax ____________

Do you give the office of Colorado Dermatology Institute permission to discuss your medical information with family members: Yes__ ☐No__ If Yes, please provide name and phone number of authorized family member (add others to back of sheet)

Name _______________________________ Relation to patient: _________________________

Day Phone: ___________________________ Evening Phone: ___________________________

Do we treat other members of your family? Yes____NO____ If yes, name of family member _______________

Picture Consent. Clinical pictures are often taken for proper charting. Do we have your permission to use these pictures for educational or promotional purposes? Yes ____ No ____

How did you hear of our Clinic? ____

ALL ITEMS ON THIS FORM ARE COMPLETE, CURRENT, AND ACCURATE.

_______________________________________ __________________

SIGNATURE **DATE**