Colorado Dermatology Institute

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 REVERSE

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**