



Patient Information Form (Please Print)

Name _____ Social Security # _____
Home Phone (____) _____
Work Phone (____) _____
Cell Phone (____) _____
E-mail _____

Preferred Name _____
Address _____
City _____ State _____ Zip _____
Birthdate _____ Age _____ Sex F M (Circle)
Did another Doctor recommend you see a Dermatologist?
Yes No (Circle)

Table with 3 columns: Race (circle)** (American Indian, Asian, Black, White, Other), Ethnicity (circle) (Hispanic/Latino, Not Hispanic/Latino, Prefer not to answer), Language Preferred (circle) (English, Spanish, Other). Includes note: **data collection and classifications are from the Centers for Medicare Services (CMS)

If yes, please list referring Doctor _____ Phone # _____
Primary Care Physician _____ Phone # _____
Person responsible for account _____ Phone # _____
In case of emergency who should be notified _____ Phone # _____ Relationship _____

Primary Insurance

Insurance Company _____
Policy Holder _____ Birthdate _____ Relation to Patient _____
Address (if different from patient's) _____ Phone (____) _____
City _____ State _____ Zip _____ Social Security # _____

Additional Insurance Is patient covered by additional insurance? Yes No

Insurance Company _____
Policy Holder _____ Birthdate _____ Relation to Patient _____
Address (if different from patient's) _____ Phone (____) _____
City _____ State _____ Zip _____ Social Security # _____

Authorization and Release (Please READ AND INITIAL each line and sign at the bottom)

- 1. Initial _____ I am responsible for payment in full at time of service unless previous arrangements have been made.
2. Initial _____ I hereby authorize the release of medical information to my insurance carrier that may be necessary to process my claim, and to any other facility or Doctor involved in my care.
3. Initial _____ I hereby authorize payment directly to Denver Dermatology Consultants, P.C. for my medical expenses.
4. Initial _____ In the event it is necessary to refer this account to collections, I/we agree to pay all costs of collection including but not limited to reasonable attorney fees, court costs and interest permitted by law.
5. Initial _____ If my insurance company denies payment, I agree to be personally and fully responsible for any of the remaining balance.
6. Initial _____ I authorize this facility to contact the patient, or authorized representative or guardian with any necessary medical information through telephone, fax or other communication.
7. Initial _____ I have read and understand the above information. I also verify that the information is correct.

X _____ Relationship to Patient _____ Date _____
Signature of Patient, Parent /Guardian or Personal Representative

For office use only: TH WR ST Patient # _____ Cosmetic / Medical Actual Provider _____