Denver Dermatology Consultants P.C.

Patient Information Form (Please Print)

Social Security #_____

Name_____
First MI Last

Home Phone (___) _____

Work Phone (___) _____

Preferred Name _____

Cell Phone (___) _____

Address _____

E-mail _____

City_____ State _____ Zip_____

Birthdate _____ Age _____ Sex F M (Circle)

Did another Doctor recommend you see a Dermatologist?
Yes No (Circle)

Race (circle)**	**Ethnicity** (circle)	**Language Preferred** (circle)
American Indian	Hispanic/Latino	English
Asian	Not Hispanic/Latino	Spanish
Black	Prefer not to answer	Other_____
White		
Other		

***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* _____

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