

# COLORADO DERMATOLOGY SPECIALISTS

REGISTRATION FORM – PLEASE PRINT

This form must be filled out entirely. Failure to do so may result in denied insurance claims, thus rendering any services your financial responsibility. \_\_\_\_\_ (please initial)

<b>PCP:</b>	<b>Today's Date:</b>
<b>PATIENT INFORMATION</b>	
Patient's last name: _____ First: _____ Middle: _____	
Is this your legal name: <input type="checkbox"/> Y <input type="checkbox"/> N	If not, what is your legal name? _____ (Former name): _____
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one)      Single    Married    Divorced    Separated    Widowed
Social Security Number: _____	DOB: _____ Age: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Cell phone: _____	Home Phone: _____ Work Phone: _____
Email Address: _____	Occupation: _____
Street address: _____	
Zip: _____	City: _____ State: _____
Referred by: _____	
Other family members seen here: _____	Spouse name: _____

<b>INSURANCE INFORMATION</b>			
(Please give your insurance card to the receptionist.)			
Person responsible for bill: <input type="checkbox"/> Self <input type="checkbox"/> Other:			Preferred Language: _____
Please indicate primary insurance:			
Subscriber's name: _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Subscriber's SSN: _____	DOB:    /    /
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:			
Group Number: _____	Policy Number: _____	Specialist co-payment: \$ _____	
Name of secondary insurance (if applicable): _____			
Subscriber's name: _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Subscriber's SSN: _____	DOB:    /    /
Group Number: _____	Policy Number: _____	Specialist co-payment: \$ _____	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:			

<b>IN CASE OF EMERGENCY</b>			
Name: _____	Relationship: _____	Home phone no.: _____	Work phone no.: _____
<p>I understand that this form must be complete in order for insurance to be billed. I consent to the release of medical information to my insurance company and to such other organizations as may be permitted under the Health Insurance Portability and Accountability Act (HIPAA). I authorize and request that any insurance benefits be paid directly to Colorado Dermatology Specialists. I understand the financial policies of this practice and agree that I am responsible for the balance on my account for services rendered. Account balances that exceed 60 days will be charged a rebilling charge of \$5.00/month. I understand that tissue removed will be sent to a laboratory for pathological examination which involved additional fees.</p>			

<b>Patient/Guardian signature:</b> _____	<b>Date:</b> _____
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## MEDICAL HISTORY

Patient's last name:	First:	Middle:
Please explain your skin concern(s) (rash, growths, warts, etc.)?		
When did you first notice this skin problem?		
Please draw on the diagram at right indicating where your present skin Problem or rash is by marking X's on the figures below.		

<b>PLEASE CIRCLE YES OR NO AND ANSWER THE FOLLOWING:</b>	
1. Has a doctor given you anything for your skin for this problem? If yes, please give the names of everything used:	YES    NO
2. Have you put anything else on your skin for this problem? If yes, please give the names of everything used:	YES    NO
3. Have you had any other skin problems? If yes, please list:	YES    NO
4. Are you currently being treated by a doctor? If yes, for what:	YES    NO
5. Have you worked as a lifeguard, used tanning beds, or ever had blistering sunburns?	YES    NO
6. Has anyone in your family had malignant melanoma or abnormal moles?	YES    NO
7. Do you have any family history of skin problems, rashes, or diseases?	YES    NO
8. How is your general health? Circle one:    Excellent    Good    Fair    Poor	
9. Does anything touching your skin cause a rash or allergy (jewelry, poison oak, etc.)?	YES    NO
10. Please list all pills, medicines or tablets you are taking including non-prescription medications/supplements:	
11. Are you allergic to any medications?	YES    NO
12. Do you now have or have you ever had eczema, hives, easy bleeding or asthma?	YES    NO
13. Is there anything else I should know about your health? (I.e. recent surgeries, diabetes, easy bleeding, etc.)	YES    NO
14. Are you interested in cosmetic procedures (i.e. Botox, dermal fillers, laser treatments)?	YES    NO
Patient/Guardian signature:	Date:

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