Patient Information ❑New Patient ❑Name Change ❑Address Change ❑Insurance Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: Today's Date ___/___/___

Name ____ Social Security #____________________
Last First M.I.

Birth Date: _____/_____/_____ Age: ______ ❑Male ❑Female Marital Status: S M D W

Mailing Address ____
City State Zip

Home Phone: ( )_________________ Work Phone: ( )_____________________

Cell Phone: ( )_________________ e-mail: ____

PARENT, SPOUSE, OR RESPONSIBLE PARTY ***(if different from patient)***

Name: ____ Birth Date: ____/____/____
Last First M.I.

Address:____
City State Zip

Home Phone: ( ) ___________________ Work Phone: ( ) _____________________

Primary Insurance Coverage: Insurance Co. Name:____

Claim Center Address:____
City State Zip

Name of Policy Holder (Insured):______________________________ Insured's Birth Date: ____/____/____

Policy #:______________________ Group Name or #:__________________ Policy Type: ❑HMO ❑PPO

If patient is a child, check relationship to insured: ❑Mother ❑Father ❑Other_______________

Secondary Insurance Coverage: Insurance Co. Name:____

Claim Center Address:____
City State Zip

Name of Policy Holder (Insured):______________________________ Insured's Birth Date: ____/____/____

Policy #:______________________ Group Name or #:__________________ Policy Type: ❑HMO ❑PPO

If patient is a child, check relationship to insured: ❑Mother ❑Father ❑Other_______________

Primary Care Provider:____

I hereby authorize the physicians at Central Colorado Dermatology to treat and furnish information to insurance carriers concerning my illness and treatment and hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance and collection costs should this account be assigned for collection.

I accept and understand the responsibility of notifying the treating physician of any requirement by my insurance company for preauthorization prior to any hospital admission or surgical procedure, whether done in office or in hospital. I understand that it is also my responsibility to verify that a preauthorization has been completed prior to any hospital admission or surgical procedure.

I also understand if I fail to get a referral, if necessary, I will be responsible for the charges. I understand I am responsible for checking my insurance benefits.

Patient's/Guarantor's/Guardian's Signature: ____

PLEASE BRING YOUR PAPERWORK WITH YOU TO YOUR APPOINTMENT — DO NOT MAIL IT.

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