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)

PCP:	Today's Date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:
Is this your legal name: ❑ Y ❑ N	If not, what is your legal name?	(Former name):
❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital status (circle one) Single Married Divorced Separated Widowed	
Social Security Number:	DOB:	Age: Sex: ❑ M ❑ F
Cell phone:	Home Phone:	Work Phone:
Email Address:		
Street address:		
Zip:	City:	State:
Referred by:		
Other family members seen here:		

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: ❑ Self ❑ Other:			Preferred Language:
Please indicate primary insurance:			
Subscriber's name:	Sex: ❑ M ❑ F	Subscriber's SSN:	DOB: / /
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:			
Group Number:	Policy Number:		Specialist co-payment: $
Name of secondary insurance (if applicable):			
Subscriber's name:	Sex: ❑ M ❑ F	Subscriber's SSN:	DOB: / /
Group Number:	Policy Number:		Specialist co-payment: $
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:			

IN CASE OF EMERGENCY

Name:	Relationship:	Home phone no.:	Work phone no.:

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.

Patient/Guardian signature:	*Date:*

Continued on other side

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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.		

McGill Pain Questionnaire

Mark with an X the exact location of your pain.

(Melzack & Torgerson, 1971)

PLEASE CIRCLE YES OR NO AND ANSWER THE FOLLOWING:	
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:*