Date: _____

Patient Information

Legal Name: _____ Nickname: _____

Date of Birth: _____ Birth Sex: _____ SSN (if Medicare/Tricare): _____

Mailing address: _____

City, State, Zip Code: _____

Cell: _____Home: _____Work: _____

OK to leave a detailed message? YES NO Preferred phone: HOME WORK CELL

Email: _____

Emergency Contact: _____Relationship: _____ Phone: _____

Marital Status: _____Occupation/Employer: _____

Race (optional): _____Ethnicity (optional): _____

Primary Care Physician (PCP): _____Phone: _____

Referring Physician Name (if not PCP): _____Phone: _____

Insurance Information:

Primary Insurance: _____

Secondary Insurance: _____

Responsible Party Information (***complete only if different than above***): _____

Name: _____ Date of Birth: _____

Mailing Address: _____

City, State, Zip Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

By signing this authorization, I verify the accuracy of my demographic information. I also authorize Colorado Dermatology Specialists to share my protected health information (PHI) with the providers I have listed on this form.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: (Please circle one) SELF GUARDIAN POWER OF ATTORNEY