BOULDER DERMATOLOGY

Today's Date: _____

MR#: _____

Patient Name: _____

Address: _____City_____State:_____Zip_____

Contact Phone: _____Alternative Phone: _____

Email: _____@_____

Age: _____Date of Birth: _____Gender: _____

Parents Name if a Minor: Mother_____
Father_____

Emergency Contact: _____Relationship_____Number_____

Referred by: _____ Primary Care Physician: _____

Pharmacy of Choice: _____ Street Address: _____

Insurance Information

Please give your insurance cards to receptionist at check in for verification and we will collect any co-payment due at time of service

(If you do not have your insurance card with you, please fill out the following)

Primary Insurance

Insurance/Policy Company_____ Policy # _____

Policy Holder: ◯ Self ◯ Spouse ◯ Partner ◯ Parent

Policy Holder Name (if not you): _____ DOB: _____

Address: _____City _____ST_____ Zip_____

Secondary Insurance

Insurance/Policy Company_____ Policy # _____

Policy Holder: ◯ Self ◯ Spouse ◯ Partner ◯ Parent

Policy Holder Name (if not you): _____ DOB: _____

Address: _____City _____ST_____ Zip_____

Authorization and Release:

I hereby authorize the physician to release any medical information to my insurance company and authorize payment directly to the physician or supplier for the surgical and/or medical benefits. I authorize the physician to release any medical information acquired in the course of my treatment necessary to process insurance claims. **I understand I am responsible for co-payments, co-insurance, deductibles, referrals and non-covered services.**

Consent for Treatment:

I hereby consent to all billing submissions, examination and treatment performed by the staff of Boulder Dermatology.

Patient/Guardian Signature: _____Date: _____

Relationship to Patient: _____