BOULDER Dermatology

PATIENT #

PATIENT INFORMATION

LAST NAME		FIRST NAME & INITIAL	
ADDRESS LINE 1		CITY	
STATE	ZIP	SOCIAL SECURITY NO.	
HOME PHONE	WORK PHONE	CELL	
DATE OF BIRTH	AGE ☐ MALE ☐ FEMALE	MARITAL STATUS	☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED
PARENTS NAME IF MINOR	MOTHER	FATHER	
REFERRING DOCTOR		PHONE	
PRIMARY DOCTOR		PHONE	
EMERGENCY NOTIFICATION		PHONE	
PATIENT'S EMPLOYER		OCCUPATION	
EMPLOYER'S ADDRESS			
CITY		STATE	ZIP
SPOUSE NAME		CELL NO.	
SPOUSE'S EMPLOYER		WORK PHONE NO.	

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY LAST NAME	FIRST NAME & INITIAL	RELATIONSHIP	
ADDRESS			
CITY	STATE	ZIP	PHONE
RESPONSIBLE PARTY DATE OF BIRTH		RESPONSIBLE PARTY S.S. NO.	
RESPONSIBLE PARTY EMPLOYER			
EMPLOYER'S ADDRESS		EMPLOYER'S PHONE	

Insurance: Please give your insurance card to the receptionist when you check in.

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, and non-covered services.

CONSENT FOR TREATMENT: I hereby consent to examination and treatment performed by the medical staff of Boulder Dermatology.

_______________________________ Date ____________________

Signature of patient, parent or guardian

REORDER # 98-05706