PATIENT REGISTRATION
PLEASE PRINT AND COMPLETE ALL BLANKS

Date _____

Patient's Name_____
Last First Middle Initial
Address_____
Street Number City State Zip

Birthdate _____/_____/_____ Age_____ Sex_____ SS# _____

Preferred Phone _____

□ Married □ Single □ Divorced □ Widowed □ Significant Other

Occupation _____ Employer_____
Employer Address _____ Business Phone_____
Person responsible for payment_____
Relationship _____ Phone_____

INSURANCE INFORMATION
Policy holder/guarantor _____ Policy holder/ Date of Birth _____
Name of Insurance Company_____SS#_____
Whom may we contact in case of emergency _____
Address _____ Phone _____

Name of Primary Care Physician
_____

PLEASE NOTE: We charge for NO SHOW appointments and appointments cancelled with less than 48 hours notice.

ABOUT FINANCIAL ARRANGEMENTS, MEDICAL INSURANCE AND NOTICE OF PRIVACY PRACTICES
We are a participating provider for many insurance companies. It is your responsibility to provide us with accurate insurance information in order to process these claims. If a referral is necessary, it is the patient's responsibility to obtain the referral before being seen. Patients who do not have a current referral may not be seen. Patients who are seen without a referral assume total financial responsibility for services rendered on that date and are expected to pay for service the day of the visit. Co-pay and Deductable will be collected at time of service. We do not bill for co-pays. Patients who are unable to pay the required co-pay before the visit may not be seen. All accounts become the patient responsibility 60 days after date of service, or immediately if the patient has not provided us with accurate insurance information. Non-covered, cosmetic, or medically unnecessary services are payable at time of service no matter what insurance plan the patient is covered under.

PLEASE NOTE: We charge for no show appointments and for appointments cancelled within 24 hours.

I hereby acknowledge that I received and understand Cherry Creek Dermatology, PC's Notice of Privacy Practices.

Returned checks and balances older than 30 days are subject to additional finance and collection fees. A finance charge of 18% per annum will be applied to all patient due balances outstanding over 30 days.

I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health insurance status or changes in the above information. I authorize release of information in my medical history to my insurance companies and assign all benefits for unpaid services to the doctor.

Signed _____ Date_____
Patient (or Guardian)

PREGNANCY AND MEDICATION RISKS

Many medications which are used routinely in women of childbearing age may not be entirely safe during pregnancy. While some such medications are known to harm the developing fetus or to interfere with the pregnancy, many are just not adequately tested to assure safety. Any delay in recognition of pregnancy may allow use of medications which may be reconsidered if pregnancy were known. Any patient who may be pregnant or who is attempting to become pregnant (or any patient who is having sexual contact without certain protection) should inform her physician before taking any prescription medication.
If you are on any medication (including over-the-counter medications) and may become pregnant during treatment, you should discuss that with your physician. If you have any questions about this information, discuss them with your physician.
Sign below indicating that you have received and understood this information and had an opportunity to have your questions answered. You may have an extra copy of this form to take home with you for your information and to discuss with your spouse or family.

Signed _____ Date_____
Patient (or Guardian)