Patient Registration Form

Full Legal Name: _____ Nickname: _____
Date of Birth: _____-_____-_____ Occupation: _____
Preferred Phone: Home Cell Work? (_____)_____ Other Phone: Home Cell Work? (_____)_____
Mailing Address: _____ City: _____ State: ___ Zip Code: _____
SSN: _____-___-_____ Email: _____ Pharmacy: _____
Referring Physician: _____

PARENT OR RESPONSIBLE PARTY ***(If different from patient)***
Name: _____ Relationship to Patient: _____
Full Address: _____
Home Phone: (_____)_____ Work Phone: (_____)_____ SS# ____-____-_____

INSURANCE INFORMATION ***(Please present insurance card at the time of check in)***
Primary Insurance _____ Insured _____ ID# _____
Group# _____ Birth Date ____-____-_____ Relationship to Patient: _____
Secondary Insurance _____ Insured _____ ID# _____
Group# _____ Birth Date ____-____-_____ Relationship to Patient: _____

Do we have permission to leave a message on your answering machine at home, or discuss your medical condition with any adult member of your household? **(Circle) Yes No**

I have authorized the release of medical information to my primary care or referring physician, to consultants as needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Payment for all services is required at the time they are rendered unless they are in a prepaid plan in which we participate. For those patients applicable, copayments and deductible will be collected at the time of service. "I understand I will be responsible for any interest (18% per annum) and/or attorney fees (and all collection fees) associated with my account." We accept payment in the form of cash, check, or credit card.
Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature _____ Date _____

Rocky Mountain Dermatology
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have had the opportunity to receive and/or review a copy of Rocky Mountain Dermatology's Notice of Privacy Practices that outlines how patient confidential information will be used, disclosed, and protected.

Printed Patient Name _____

Printed Name/Relationship of Responsible Party _____

Signature _____

Date _____