ROCKY MOUNTAIN Dermatology
MEDICAL • SURGICAL • COSMETIC

Please fill out the following form in its entirety. Your health and privacy are important to us! In accordance with national HIPAA laws, the information you provide will be kept strictly confidential and shared only with your written consent and authorization. We collect this information to better care and provide for you as our patient, as well as to comply with national requirements and policies that seek to improve the healthcare and wellbeing of patients throughout the country. In addition, having accurate information helps us coordinate effectively with your insurance to ensure you receive timely, optimal, and accurate coverage available for your treatment. Thank you for letting us serve you!

Patient Information

Full Legal Name:_____ Preferred Name:_____

Date of Birth: _____ Age:_____ SSN:_____

Birth Sex: Male Female Gender Identity:_____ Sexual Orientation:_____

Ethnicity:_____ Race:_____ Preferred Language:_____

Marital Status:_____ Previous Name:_____

Street Address (including City, State, Zip):_____

Mailing Address (if different than above):_____

Primary Contact Phone Number: _____ Home Cell Work

Alternate Phone Number: _____ Home Cell Work

Email address: _____ Would you like to receive email notifications? Yes No

Emergency Contact

Name:_____ Phone Number:_____

Relationship to Patient:_____

Responsible Party (if different from patient)

Name:_____ Date of Birth:_____ Relationship to Patient:_____

Preferred Phone Number:_____ SSN:_____

Street Address (including City, State, Zip):_____

Mailing Address (if different than above):_____

Employer:_____ Employer Phone:_____

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Insurance Information

Primary Insurance Policy

Policy Holder:_____ Date of Birth:_____

Policy Holder SSN: _____ Relationship to Patient: _____

Policy Holder Address:_____

Insurance Company Name:_____ Policy ID Number:_____

Secondary Insurance Policy

Policy Holder:_____ Date of Birth:_____

Policy Holder SSN: _____ Relationship to Patient: _____

Policy Holder Address:_____

Insurance Company Name:_____ Policy ID Number:_____

Private Health Information Release

Rocky Mountain Dermatology and Young Skin Care are committed to protecting your privacy and personal information. In order to best fulfill this responsibility, we only share private health information with authorized individuals. For further information regarding our Privacy Practices, please reference the attached Privacy Notice.

I hereby authorize Rocky Mountain Dermatology and Young Skin Care to discuss my medical care, test results, and/or billing with the following individuals:

Name:_____ Phone Number:_____ Relationship to Patient:_____

Name:_____ Phone Number:_____ Relationship to Patient:_____

I hereby acknowledge and confirm that the above information is accurate and correct to the best of my knowledge:

Patient/Responsible Party Signature:_____ **Date**:_____