



MONTROSE
DERMATOLOGY
+ Cosmetics

1563 Ogden Road, Montrose CO 81401

voice 970-964-4036 fax 970-964-4038

www.montrosedermatology.com

Renata Raziano, MD PhD

Patient Registration Form

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City, State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Best Number to leave an Appointment Reminder call: ___ Home ___ Cell

Email: _____

SSN: _____ Date of birth: _____ Age: _____

Sex: M F

Married Single Divorced Widow

Employed by: _____ Work Phone #: _____

Address: _____

City, State: _____ Zip Code: _____

Parent/Guardian name for Minors (under the age of 18): _____

SSN: _____ Date of birth: _____

Billing Address: _____

Others we may share your health information with (such as biopsy results, etc):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name of Primary Physician: _____

Address (if known): _____

City, State: _____ Zip Code: _____ Office Phone#: _____

How did you learn about our practice? _____

Insurance Information:

Are you the holder of the medical insurance card policy?

YES NO (If NO, please complete below)

Name of Policy Holder: _____

Relationship to Patient: _____

Policy Holder's Date of Birth: _____

Policy Holder's SSN: _____

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co-pay, and non-covered service amounts. See our complete financial policy for details.

Signed: _____
(Patient or Responsible Party)

Date: _____

I authorize the release of any medical information necessary to process my claim.

Signed: _____
(Patient or Responsible Party)

Date: _____

I authorize payment of medical and surgical benefits to Renata Raziano, MD.

Signed: _____
(Patient or Responsible Party)

Date: _____

*****Workers Compensation Information (If applicable):*****

Did your injury happen on the job? Yes No

If yes, on what date did the injury occur? _____

Did you report the accident to your employer? Yes No

It is your responsibility to make sure you have verified authorization with your case manager to see a specialist prior to your appointment. Workers compensation does not usually allow for self referrals.

Name: _____

Date of Birth: _____

History and Intake Form

Past Medical History: (please circle all that apply)

Autoimmune disease	Coronary Artery Disease	Leukemia
Anxiety	Depression	Lung Cancer
Arthritis	Diabetes	Lupus
Asthma	End Stage Renal Disease	Lymphoma
Atrial fibrillation	GERD	Prostate Cancer
Bone Marrow Transplantation	Hearing Loss	Radiation Treatment
Breast Cancer	Hepatitis	Seizures
Colon Cancer	High Blood pressure	Stroke
COPD	HIV/AIDS	
	High Cholesterol	NONE
	Thyroid Problems	
Other		

Past Surgical History: (please circle all that apply)

Appendix Removed	Joint Replacement, Hip (Right, Left, Bilateral)
Bladder Removed	Kidney Removed (Right, Left)
Cataract surgery	Kidney Stone Removal
Mastectomy (Right, Left, Bilateral)	Kidney Transplant
Lumpectomy (Right, Left, Bilateral)	Ovary removal
Breast Reduction	Prostate Removed: Prostate Cancer
Breast Implants	Tonsillectomy
Colon removal	Tubal ligation
Gallbladder Removed	TURP (Prostate Removal)
Coronary Artery Bypass	Spleen Removed
Mechanical Valve Replacement	Testicles Removed (Right, Left, Bilateral)
Biological Valve Replacement	Hysterectomy
Heart Transplant	
Joint Replacement, Knee (Right, Left, Bilateral)	NONE
Other	

Skin Disease History: (please circle all that apply)

Acne	Eczema	Vitiligo
Actinic Keratoses	Hay Fever/Allergies	
	Psoriasis	NONE
Other		

Name: _____

Date of Birth: _____

Skin Cancer History

Basal Cell Carcinoma: list locations and dates

Squamous Cell Carcinoma: list locations and dates

Melanoma: list locations, dates and thickness (if known)

Have you ever used a tanning bed? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)?

Medications: (Please enter all current medications)

Medication Allergies: (Please enter all allergies) OR **No Known Drug Allergies**

Social History: (Please circle all that apply)

Cigarette Smoking:

- Currently Smokes
- Has smoked in the past
- Never smoked
- Former Smoker

Alcohol Use:

- EtOH- None
- EtOH- less than 1 drink per day
- EtOH -1-2 drinks per day
- EtOH -3 or more drinks per day

Recreational drug use? NO YES _____

Name: _____

Date of Birth: _____

Family History (Only parents and siblings)

Diabetes Stroke Heart Attack Cancer _____

Other _____

Primary Care Provider: _____

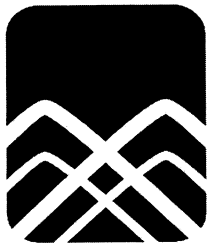
Phone #: _____

City: _____

Preferred Pharmacy Name: _____

City or Zip Code: _____

Reason for your appointment with Montrose Dermatology:



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Policies and information:

Basic Policies:

- Please be on time for your appointments.
- If you are late for your scheduled appointment, there is a chance that you will be rescheduled.
- We require at least 24 hours notice to cancel appointments. If you miss two consecutive appointments you will be required to prepay your next appointment in order to reschedule. If you miss a third appointment you will be discharged from the practice. These rules are subject to change at the provider's discretion. Failure to show for appointments without prior notification *may* result in fees.
- Patients under the age of 18 require a parent or guardian that can legally give consent for treatment for the minor patient to be present at all appointments.
- Payment for services is due in full at the time the service is provided in our office.

Pathology Billing:

_____ Initials

****Please Note:** In the event that a pathology specimen is sent out for processing, you will receive bills for these services from an outside agency. The majority of these are sent to University of Utah Health Care (800-245-0357). Please contact that agency with questions regarding billing, etc. You should inquire with your insurance company for particular coverage at this facility prior to your appointment if possible.

Financial Policies:

Insurance Coverage

We will bill most insurance carriers if proper identification is provided to us. Insurance cards must be present along with a valid picture ID in order for us to bill your insurance for you. Copayments are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for your care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.

Communicating changes to your insurance is your responsibility

If you fail to communicate changes in insurance, you may be responsible for paying your medical bill out of pocket.

Surgery Fees

All co-pays, deductibles, and payments for non-covered surgical procedures are due prior to your surgery. Prior authorization may be required by your carrier and this is your responsibility to obtain this prior to your procedure.

Non-covered Services

Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

NSF Checks (Checks that are returned by the bank unpaid)

There will be a fee of \$35.00 added to the account balance in the event that a check is returned unpaid.

Balances Sent to Collections

In the event your account has a balance after all attempts have been made to collect said balance, your account will be forwarded to an outside collection agency. If your account is sent to collection, you are responsible for all amounts due plus costs of collection including:

- Handling charge up to fifty percent (50%) of your account balance if it must be sent to collection.
- All collection expenses charged by the collection agency.
- Court costs and attorneys' fees.

Patients that have been sent to collections will be discharged from the clinic.

Personal Injury Cases

This office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment in full at the time of service. We do not accept liens.

Release of Information

I authorize Montrose Dermatology to release to my insurance carrier(s) and/or CMS and its agents and/or my secondary insurer any information needed to determine benefits or benefits payable for related services.

I hereby authorize health providers at Montrose Dermatology to release any information regarding services rendered by him/her and allow a photocopy of my signature to be used to file insurance.

I hereby authorize and direct my insurer to issue payment check(s) for benefits due me for the services rendered by any providers affiliated with Montrose Dermatology. Regardless of my insurance benefits, if any, I understand I am financially responsible for the fees for services rendered.

I have read and agree to the Financial Policy and Release of Information paragraphs stated above that apply to me.

Patient or Responsible Party signature

Date

Printed Name of Patient or Responsible Party

DOB of Patient

Relationship to Patient

Phone



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**Receipt of Notice of Privacy Practices
Written Acknowledgement Form**

I am a patient of Montrose Dermatology. I hereby acknowledge receipt of Montrose Dermatology's Notice of Privacy Practices.

Signature: _____

Print Name: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name].

I hereby acknowledge receipt of Montrose Dermatology's Notice of Privacy Practices with respect to the patient.

Signature: _____

Relationship to Patient: Parent Legal Guardian

Print Name: _____

Date: _____