MONTROSE DERMATOLOGY + Cosmetics

1563 Ogden Road, Montrose CO 81401
voice: 970-964-4036 fax: 970-964-4038
www.MontroseDermatology.com

Patient Registration Form

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

Married ☐ Single ☐ Divorced ☐ Widow(er) ☐ SSN:_____

Date of Birth:_____Age:_____ Sex: M ☐ F ☐

Please Circle	▪ English	▪ Declined	▪ White	▪ American Indian	
Preferred	▪ Spanish	Ethnic	▪ Unknown	Race:	▪ African American/Black	▪ Other _____
Language:	▪ Other	Group:	▪ Hispanic/Latino		▪ Asian	▪ Declined
	▪ Declined		▪ Not Hispanic/Latino			

Email:_____

Address: _____

City, State: _____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

Best Number to leave an Appointment Reminder call: ____ Home ____Cell - Is it ok to leave a detailed message? Y or N

Emergency Contact Name:_____ Phone: _____

Employed by:_____Work Phone #:_____

Address: _____

City, State:_____ Zip Code:_____

Name of Primary Physician: _____

Address (if known): _____

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

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

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

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

SSN:_____ Date of birth:_____

Billing Address:_____

How did you learn about our practice? _____

Insurance Information: **Self Pay** ☐ **Insurance** ☐

***PLEASE bring your insurance cards & a photo ID with you to your appointment**

Primary Policy

Name of Insurance:_____

Policy or Member #:_____ Group #:_____

Insurance Address & Phone #:_____

Secondary Policy

Name of Insurance:_____

Policy or Member #:_____ Group #:_____

Insurance Address & Phone #:_____

Additional Ins

Name of Insurance: _____

Policy or Member #:_____ Group #:_____

Insurance Address & Phone #:_____

If you are not the policy holder of an insurance listed above, please fill in the information below.

Name of Insurance: _____

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:_____ Date:_____
(Patient or Responsible Party)

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

Signed: _____ Date:_____
(Patient or Responsible Party)

I authorize payment of medical and surgical benefits to Montrose Dermatology.

Signed: _____ Date:_____
(Patient or Responsible Party)

Name:_____
Date of Birth:_____

History and Intake Form

Past Medical History: (please circle all that apply) OR **NONE**

Autoimmune disease
Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol
Thyroid Problems
Leukemia
Lung Cancer
Lupus
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

Other

Past Surgical History: (please circle all that apply) OR **NONE**

Appendix Removed
Bladder Removed
Cataract surgery
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colon removal
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovary removal
Prostate Removed: Prostate Cancer
Tonsillectomy
Tubal ligation
TURP (Prostate Removal)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy

Other

Skin Disease History: (please circle all that apply) OR **NONE**

Acne
Actinic Keratoses
Eczema
Hay Fever/Allergies
Psoriasis
Vitiligo

Other

Name:_____
Date of Birth:_____

Miscellaneous:
Have you *ever* used a tanning bed? Yes No

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

Skin Cancer History: OR **NONE**

Basal Cell Carcinoma: list locations and dates
_____
_____
_____

Squamous Cell Carcinoma: list locations and dates
_____
_____
_____

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

Medications: (Please enter all current medications) OR **NONE**
_____
_____
_____
_____

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) OR **NONE**

Diabetes Stroke Heart Attack Cancer_____
Other_____
_____

Primary Care Provider (Doctor's Name): _____

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.

Refunds
Deposits made for cosmetic services are not eligible for refunds except in extenuating circumstances. Please be advised your request for a refund may be denied.

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: _____