

**PATIENT INFORMATION:**

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ Mr. Mrs. Ms. Miss  
Last First MI Circle one  
PHONE: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
Street Address City State Zip Code

BIRTHDATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_ SSN: \_\_\_\_\_ SEX: M \_\_\_\_ F \_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_ SPOUSE'S NAME: \_\_\_\_\_

PATIENT'S PERSONAL PHYSICIAN: \_\_\_\_\_

**REFERRED BY?:** \_\_\_\_\_ **MD/PA/NP WHICH OFFICE?:** \_\_\_\_\_  
Circle one

EMERGENCY CONTACT: \_\_\_\_\_  
Name Phone #

**BILLING INFORMATION:** (Write "same" if patient, otherwise please provide information) *If **STUDENT** please put parents information here.*

RESPONSIBLE PARTY: \_\_\_\_\_  
Last First MI

ADDRESS: \_\_\_\_\_  
Street Address City State Zip Code

**INSURANCE:**

PRIMARY INS CO: \_\_\_\_\_ POLICY HOLDER'S NAME: \_\_\_\_\_ D.O.B. (\_\_\_\_/\_\_\_\_/\_\_\_\_)

EMPLOYER: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ SSN: \_\_\_\_\_

SECONDARY INS CO: \_\_\_\_\_ POLICY HOLDER'S NAME: \_\_\_\_\_ D.O.B. (\_\_\_\_/\_\_\_\_/\_\_\_\_)

EMPLOYER: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ SSN: \_\_\_\_\_

**PRIVACY NOTICE  
PLEASE READ, SIGN AND DATE**

I acknowledge that I understand the privacy policies mandated by the Health Insurance Portability and Accountability Act (HIPAA) that went into effect April 14, 2003.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

RESPONSIBLE PARTY SIGNATURE IF PATIENT IS A MINOR: \_\_\_\_\_

**FINANCIAL AGREEMENT & INSURANCE AUTHORIZATION  
PLEASE READ, SIGN AND DATE**

I request that payment of authorized Medicare / Medigap or other insurance benefits be made on my behalf to the Fort Collins Skin Clinic, P.C. for any services furnished to me by either physician / supplier. I authorize the Fort Collins Skin Clinic, P.C. to release to the Health Care Financing Administration and its agents or my insurance company any information needed to determine these benefits payable for related services. **I understand that I am responsible for understanding my insurance coverage. I understand that prior authorization of services does not necessarily guarantee payment. I understand that I am responsible for any deductibles, coinsurance, co-pays and services deemed not medically necessary by my insurance carrier.**

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

RESPONSIBLE PARTY SIGNATURE IF PATIENT IS A MINOR: \_\_\_\_\_

**Fort Collins Skin Clinic**  
**Health Summary**

Would you like information about cosmetic procedures?  
Y / N

Updated: \_\_\_\_\_  
\_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Drug Allergies		In Office Medications	
<b>Medications/Dosage</b>	Include vitamins/supplements		

Past & Present Health Conditions

YES	NO	DISEASE	YES	NO	DISEASE
		Irregular Heart Beat			Prostate Problems
		Congestive Heart Failure			Gout
		Heart Attack			Arthritis
		Heart Murmur			Skin Disease, Type:
		Rheumatic Fever			Skin Cancer, Type:
		High Cholesterol			Family history of Skin Cancer
		High Blood Pressure			Stroke
		Asthma			Epilepsy / Seizures
		Emphysema / Chronic Bronchitis			Diabetes / High Blood Sugar
		Blood Clot			Thyroid Problems – too high or low
		Hepatitis			Anemia / Low Blood
		Tuberculosis			Bleeding Problems, Type:
		Gallstones			Blood Transfusion
		Liver Disease, Type:			Cancer, Type:
		Ulcers in Bowels / Stomach			Anxiety
		Bleeding from Bowels			Depression
		Kidney Disease, Type:			Glaucoma
		Kidney Stones			Other:

Surgeries

YES	NO	SURGERY	YES	NO	SURGERY
		Heart Valve Replacement			Joint Scope Surgery
		Pacemaker Placement			Joint Replacement / Date:
		Neck Artery Surgery			Back Disc Surgery
		Open Heart Surgery / Catheterization			Prostate Surgery
		Gallbladder Removal			Hernia Surgery
		Abdominal Surgery			Hysterectomy
		Broken Bone Repair			Other:

Have you ever smoked:  Yes  No How many years did you smoke? \_\_\_\_\_ When did you quit? \_\_\_\_\_  
How many packs per day do you smoke now? \_\_\_\_\_ Do you use smokeless tobacco:  Yes  No

**The following questions are very important and strictly confidential. Please answer them accurately.**  
Do you drink alcohol:  Yes  No How much? \_\_\_\_\_ How often? \_\_\_\_\_  
Do you have a history of substance abuse?:  Yes  No What kind? \_\_\_\_\_  
Are you currently using drugs?  Yes  No How much? \_\_\_\_\_ How often? \_\_\_\_\_

**Female Patients Only**  
Number of Pregnancies: \_\_\_\_\_ Are you currently pregnant:  Yes  No Trying for pregnancy:  Yes  No  
When was your last menstruation? \_\_\_\_\_ How old were you when you went through Menopause? \_\_\_\_\_

**The above information is current and correct to the best of my knowledge. I have reviewed the above history**

\_\_\_\_\_  
Patient / Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Initials Date

# Fort Collins Skin Clinic

## Permission to Release Medical Information

The Fort Collins Skin Clinic has my permission to leave personal medical information in the following locations in the event that I cannot be reached directly:

*Please Initial:*

YES	NO	N/A	
_____	_____	_____	Home answering machine/voicemail
_____	_____	_____	Work voicemail
_____	_____	_____	OK to discuss info / results with Family member: _____ Relationship: _____

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**Fort Collins Skin Clinic**  
**Financial Policy Addendum (2008)**

It is the responsibility of all patients/guarantors to understand their insurance. Please be advised that many procedures that are performed in this office may apply to your annual deductible or may require additional out-of-pocket expense beyond your co-pay (ie. co-insurance). **These tests or treatments are necessary to insure proper diagnosis and care for our patients.**

All biopsies and mole removals performed in this office will be submitted to pathology for analysis. This is an example of a procedure that could be subject to a deductible and co-insurance.

Other examples include:

- Liquid nitrogen for the destruction of lesions (warts, pre-cancerous lesions)
- Surgery for skin cancer removal and atypical moles
- Injections
- Photodynamic therapy
- PUVA light box treatments

It is important for our patients to be aware that a covered benefit does not always mean it will be paid for if you have not met your annual deductible.

I have read and understand the above.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian signature (if under 18 years of age): \_\_\_\_\_