INTEGRATED DERMATOLOGY OF MONTROSE

3480 WOLVERINE DR. SUITE F
MONTROSE, CO 81401
970-252-7444 PHONE
970-252-3446 FAX

Patient Information

Name: _____ Social Security #: _____

Street Address: _____Email: _____

City: _____State: _____Zip Code: _____

Home Phone: _____Work: _____Cell: _____

Date of Birth: _____Age: _____Gender: _____Female: _____Male: _____

Marital Status: _____ Married _____ Single _____ Divorced_____ Widowed

Profession: _____Employer: _____

Reason for Consultation: _____

Referred by: _____

Responsible Party

Please provide the following information if someone other than the patient is responsible for payment.

Name: _____Social Security #: _____

Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Emergency Contact

Name: _____ Relationship: _____

Home Phone: _____ Cell _____

Insurance Information

Primary Insurance: _____Subscribers Name: _____

Subscribers Birthdate: ___/___/___ Subscribers SSN: _____

Policy Number: _____ Group Name: _____ Group Number: _____

Secondary Insurance: _____Policy Number: _____

Relationship to Subscriber: _____

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BILLING INFORMATION

Dear Patients:

Every Insurance plan is different. We strongly recommend that you check with your insurance carrier regarding your plan's benefits and coverage. You may also want to check with your insurance company prior to consenting to laboratory / pathology testing or in-office procedures in order to determine what will be covered.

In Office procedures:

Routine in-office procedures include but are not limited to biopsies, injections, destruction of precancerous and non-cancerous growths and surgical removal and repair of cancerous and non-cancerous growths. These are billed separately from your office visit and may or may not be covered by your insurance or be applied toward your deductible.

Do we have permission to leave a message regarding your medical conditions and or test results on an answering machine? _____Yes _____No

Do we have your permission to discuss your medical condition with and or give test results to a family member? _____Yes _____No

Laboratory / Pathology Services:

Your provider will order the laboratory tests that are necessary to provide the best plan of care to you. Routine laboratory services include pathologic evaluation of skin biopsy or excision specimens and scrapings and are billed separately by that facility.

Medical Information Release:

I authorize payment of medical benefits to my physician. I acknowledge that I have been notified and offered a copy of the Integrated Dermatology of Montrose Notice of Privacy Practices.

Cancellation Policy:

Our office strives to provide you with exceptional medical care provided in a warm, professional environment. In order to ensure timely scheduling for all patients, we require 24 hour notice to cancel an appointment. If not, a cancellation fee of $50.00 will be charged to your account. Family emergencies or weather related delays will be handled on a case by case basis. We also reserve the right to charge a $50.00 cancellation fee if a patient fails to cancel a scheduled appointment.

Acknowledgement: Signature of this form indicates that you understand that you are responsible for payment of your account at the time of service for deductibles, non-covered services, medically unnecessary services, co-payments and insurance balances, should my primary insurance be with a company with which the physicians are contracted. If my insurance company is not one whit which the physician is contracted, I am responsible for the entire amount at the time of service.

If your account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, you will be responsible for all costs of collection, including but not limited to interest, re-billing fees, court costs, attorney fees and collection agency costs.

Signature of Responsible Party _____Date_____
Print Patient's Name _____DOB_____

Name: _____

Skin Disease History: (please circle all that apply)

Acne	Flaking or Itchy Scalp
Actinic Keratosis	Hay Fever /Allergies
Asthma	Melanoma
Basal Cell Skin Cancer	Poison Ivy
Blistering Sunburns	Precancerous Moles
Dry Skin	Psoriasis
Eczema	None
Squamous Cell Skin Cancer	Other_____

Do you wear sunscreen? Yes_____ No_____
If yes, what SPF? _____
Do you tan in a tanning Salon? Yes_____ No_____

Family History: (please circle all that apply)

Abnormal Moles	Eczema
Allergies	Thyroid Disorder
Asthma	Malignant Melanoma
Inflamed Bowel	Psoriasis

Medications: Please enter all current medications

_____ _____ _____
_____ _____ _____

Review of Symptom: (please circle all that apply)

Easy Bleeding	Environmental Allergies
Blood Clots	Food Allergies

Allergies: Please enter all allergies and reactions _____
_____

Females: Pregnant? Yes_____ No_____

Social History: (please circle all that apply)

Cigarette Smoking	Alcohol Use:	Language:
Never Smoked	Yes Social	English
Quit (Former Smoker)	Moderate use	Spanish
Smokes Daily	None	Other_____
Smokes Less Than Daily		

Race:	Ethnicity:
White	Hispanic / Latino
Black / African American	Non- Hispanic / Latino
American Indian or Native Alaskan	Native Hawaiian / Pacific Islander

Pharmacy Name: _____City_____ Zip Code_____