SKIN CANCER & DERMATOLOGY CENTER OF COLORADO SPRINGS, PC

PLEASE PRINT AND GIVE ALL INSURANCE CARDS, DRIVERS LICENSE TO THE MEDICAL RECEPTIONIST

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Sex: ☐ M ☐ F	☐ Mr. ☐ Mrs. ☐ Dr ☐ Ms. ☐ Miss

Street Address:	City:	State:	ZIP Code:

Home Phone No.: ( )	Employer Phone No.: ( )	Cell Phone No.: ( )

Preferred Phone No.: (circle one)	Marital Status: (circle one)	Date of Birth:	Social Security No.:
Home Work Cell Other: _____	Single Married Divorced Separated Widowed Other	/ /	

Email Address:	Employer:

PRIMARY INSURANCE INFORMATION

Primary Insurance:	Subscriber's Name: (if different than above)	Group No.:	Policy No.:

Copayment: $	Relationship to the Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other	Address of Subscriber: (if different than above)	Sex: ☐ M ☐ F	Home Cell Work No: (circle one) ( )

Subscriber's Date of Birth: (if different than above) / /	Subscriber's Social Security No: (if different than above)	Employer: (if different than above)

SECONDARY INSURANCE INFORMATION

Secondary Insurance (if applicable):	Subscriber's Name: (if different than above)	Group No.:	Policy No:

Copayment: $	Relationship to the Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other	Address of Subscriber: (if different than above)	Sex: ☐ M ☐ F	Home Cell Work No: (circle one) ( )

Subscriber's Date of Birth: (if different than above) / /	Subscriber's Social Security No: (if different than above)	Employer: (if different than above)

TERTIARY INSURANCE INFORMATION

Tertiary Insurance (if applicable):	Subscriber's Name and DOB: (if different than above)	Group No.:	Policy No:

Copayment: $	Relationship to the Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other	Address of Subscriber: (if different than above)	Sex: ☐ M ☐ F	Home Cell Work No: (circle one) ( )

If you wish the responsible party to be someone other than the primary subscriber, please list the name, address, DOB, employer and relationship to the patient below. Otherwise, it will default to the primary subscriber.

Name: _____ Address: _____

DOB: _____ Relationship to the patient: _____ Phone: _____

Referred By: (please check appropriate box)

☐ **Dr. :**_____ ☐ **Friend/Relative** ☐ **Internet** ☐ **Yellow Pages** ☐ **Website** ☐ **Other**

Primary Care Physician Name:

IN CASE OF EMERGENCY

Name of Spouse/Relative/Friend :	Relationship to patient:	Home Cell Work No.: (circle one) ( )

By signing below, I authorize treatment from Skin Cancer & Dermatology Center. I authorize my insurance benefits to be paid directly to the provider/practice. I understand that I am financially responsible for any balance. I also authorize Skin Cancer & Dermatology Center of Colorado Springs, PC or my insurance company to release any information required to process my claims. The above information is true to the best of my knowledge.

Patient/Guardian Signature:	***Printed Name:***	***Date:***

Mailing address: 1975 Research Parkway, Suite 165, Colorado Springs, CO 80920 / Phone: 719-574-0310 / Fax: 719-574-6574

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