

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: <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr <input type="checkbox"/> Ms. <input type="checkbox"/> Miss |
| Mailing Address: | | | City: | State: | ZIP Code: |
| Home Phone No.: () | | Employer Phone No.: () | | Cell Phone No.: () | |
| Preferred Phone No.: (circle one) Home / Work / Cell / Other: _____ | | Marital Status: (circle one) Single / Married / Divorced Separated / Widowed / Other | | Date of Birth: | Social Security No.: |
| Email Address: | | | Employer: | | |

PRIMARY INSURANCE INFORMATION

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|---|---|---|--|---|--|
| Primary Insurance: | | Subscriber's Name: (if different than above) | | Group No.: | Policy No.: |
| Copayment: \$ | Relationship to the Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other | Address of Subscriber: (if different than above) | | Sex: <input type="checkbox"/> M <input type="checkbox"/> 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

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|---|---|---|--|---|--|
| Secondary Insurance (if applicable): | | Subscriber's Name: (if different than above) | | Group No.: | Policy No.: |
| Copayment: \$ | Relationship to the Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other | Address of Subscriber: (if different than above) | | Sex: <input type="checkbox"/> M <input type="checkbox"/> 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

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|-------------------------------------|---|--|--|---|--|
| Tertiary Insurance (if applicable): | | Subscriber's Name and DOB: (if different than above) | | Group No.: | Policy No.: |
| Copayment: \$ | Relationship to the Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other | Address of Subscriber: (if different than above) | | Sex: <input type="checkbox"/> M <input type="checkbox"/> 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: _____ |
|--|----------------------------|--------------------|