**Kallgren Dermatology Clinic**
3434 47th St. Suite 200 Boulder, CO 80301
303-444-8100

Patient Registration Form

NAME ______________________________________________________________________________

ADDRESS____________________________________________________________________________

ZIP CODE________________CITY_______________________________________________STATE ______________

SSN ___________________________________________ Date of Birth __________________________________

Primary Phone __________________________________Type: **Circle One:** Home Cell Business

Secondary Phone _______________________________Type: **Circle One:** Home Cell Business

Gender: **Circle One:** Male Female Marital Status: **Circle One:** S M W DP

Employment Status: **Circle One:** Employed Not Employed Retired

Employer _______________________________________________________Phone _________________________

Student Status: **Circle One:** Full Time Part Time School:___________________________________

Emergency Contact _______________________________ _____________Phone ___________________________
Relationship_____________________________

May we leave personal medical information on your answering machine or cell phone? Y or N

May we discuss your medical condition with any member of your family? Y or N

If yes whom? _______________________________________________Relationship ______________________

PRIMARY CARE PROVIDER_______________________________________ PHONE ___________________________

OTHER REFERRING PHYSICIAN_______________________________________PHONE ________________________

PHARMACY LOCATION _________________________________________________________________________

NAME OF INSURANCE CO______________________________________________________________________

MEMBER # _______________________________________________GROUP #______________________________

**NAME OF PRIMARY INSURED___**_____________________________________________________________

ADDRESS
____________________________________________________________________________________________

CITY __________________________________________STATE _______________ ZIP CODE __________________

PHONE NUMBER _______________________________________________ DATE OF BIRTH __________________

RELATIONSHIP __________________________________________________

BY SIGNING BELOW I ACKNOWLEDGE THAT THE ABOVE INFORMATION IS CORRECT. I AM ALSO AUTHORIZING THE BILLING OF THE ABOVE MENTIONED INSURANCE COMPANY.

Patient Signature (Parent if minor) ________________________________________Date______________________

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Medical History Form

Name: ________________________________ DOB: ____ /____ /____ Today's Date: ____ /____ /____

Reason for today's visit:
_______________________________________________________________________________

**Medical history:** Please indicate all medical conditions or diseases you have now, or have had in the past:

__ Asthma
__ Emphysema
__ Allergies/hay fever
__ Hepatitis
__ HIV/AIDS
__ Diabetes
__ High Blood Pressure
__ High Cholesterol conditions
__ Heart disease
__ Heart Attack

__ Stroke
__ Seizures
__ Cataracts
__ HSV/cold sores
__ Arthritis: osteo /RA/psoriatic
__ Artificial Joint _____________
__ Cancer
- what type? _______________
__ Radiation therapy
__ Thyroid: hypo or hyper

Any other conditions of:
__ Liver
__ Urinary system
__ Gastrointestinal system
__ Genital system
__ Hormonal system
__ Kidney problems
__ Neuromuscular
__ Mental health condition
Please explain:
_______________________________________________________________________________

__ Pacemaker

List any other diseases or conditions:
_______________________________________________________________________________

List surgical procedures you have had in the last 6 months:
_______________________________________________________________________________

List all other major surgeries in your lifetime:
_______________________________________________________________________________

Have you ever received anesthesia/numbing at the dentist? YES or NO Any adverse reaction? YES or NO
Do you require antibiotics prior to dental or medical procedures? YES or NO
(Women) Are you currently pregnant or planning a pregnancy?

YES or NO Due Date: ____ /____ /____

**Skin/Dermatology History:**
Have you ever had skin cancer? YES or NO Type & location?
_______________________________________________________________________________

Do you have a history of any other skin conditions? YES or No Type?
_______________________________________________________________________________

Do you have problems with healing? YES or NO
Do you bleed easily? YES or NO
Do you develop skin rashes in reaction to (please circle if YES):
Medication, Food, Environment, Bandages, Topical Neosporin, Other
_______________________________________________________________________________

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**Family History:**
Has anyone in your family had melanoma? YES or NO Who? _________________
other skin cancer (basal or squamous)? YES or NO Who? _________________
Any family history of other skin conditions? YES or NO Who? _________________

**Medications:** List all current prescriptions, over-the-counter meds, vitamins, herbs, and supplements:
______________________________________________________________________________________
______________________________________________________________________________________
________________________

**Allergies:** Are you allergic to any medications? YES or NO If yes, please list medications and your reaction:
______________________________________________________________________________________
____________

**Social History:**
Do you use tobacco products? ___never ___formerly _____currently (type/amount per day? __________________)
Do you drink alcohol? Y or N How much per day? ___less than 1 drink ___1-2 drinks ___3 or more drinks
Do you use recreational/illicit drugs? Y or N If YES, what? ___________________ How often? ________________
What is your occupation? _____________________________
Hobbies?_______________________________________

Patient signature (parent if minor): _____________________________________**Reviewed by:**

**Date:**_____________________________

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## FINANCIAL POLICY/PATIENT WAIVER

**Please Note:** Complete insurance and personal information is required at the time of your appointment in order for our office to file a claim to your insurance company.

Your Insurance policy is an agreement between you and your insurance company. Our relationship is with you, and not your insurance company. Therefore, all charges are ultimately your responsibility, regardless of your insurance status. Questions regarding your insurance coverages and benefits are best directed to and answered by your insurance company.

### Waiver

______No Insurance card - I understand if I don't produce a valid insurance card within 5 business days of my appointment, I will be financial liable for payment in full. In lieu of payment in full, a valid credit card will be kept on file. If at the end of 5 business days we haven't received a copy of your valid insurance card your credit card will be charged for any and all balance(s) resulting from this appointment.

_______ No Referral/PCP - I understand that I am seeing a practitioner today at Kallgren Dermatology Clinic without a current referral in place from my Primary Care Physician. I also understand that it is my responsibility to ensure Kallgren Dermatology Clinic receives this referral within 3 business days in order for my insurance to be billed. If a referral is not received for any reason for this appointment, I understand that I will be financial liable for the full amount of any and all direct and/or ancillary charges related to this visit.

_______Forfeiture of Benefits - Although I am insured, I am choosing to be seen today as a self-pay patient. I understand that I will be financially liable for the full amount of direct and/or ancillary charges related to this visit.

_______Non Contracted Commercial Insurance, Travel Insurance, Out of Country Insurance - In the absence of a contract, Kallgren Dermatology Clinic, is unable to financially hold your insurance company responsible for your visit. I understand that I will be financial liable for the full amount of any and all direct and/or ancillary charges related to this visit.

________Medicare - We will file Medicare claims on your behalf. I understand that it is my responsibility to provide supplemental insurance information to the front desk at the date and time of my appointment. Any remaining charges will be billed to your secondary insurance once processed by Medicare.

Though Kallgren Dermatology Clinic may be a contracted provider with my insurance company, I understand that some or all of the services which are requested and rendered may not be deemed a "covered" service under my particular plan. I am responsible to pay Kallgren Dermatology Clinic for any copayment as instructed by my insurance company, any unsatisfied deductible, co-insurance or termination of coverage, and any amount considered non-covered by my insurance company. Should my insurance company or any benefits provided by that insurance company change, I will immediately notify Kallgren Dermatology Clinic of said changes.

**I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION PROVIDED TO ME AND AGREE TO BE FIANANCIALLY RESPONSIBLE FOR SERVICES RENDERED BY KALLGREN DERMATOLOGY CLINIC.**

Patient Signature (Parent if a minor) Date

______________________________________________________________ ___________________

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**RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN FORM**

I, (patient name) _______________________________________________ have read a copy of Kallgren Dermatology Clinic's Notice of Patient Privacy Practices.

Name of person(s) we may discuss your information. Relationship

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Patient Signature (parent if minor) Date

The above authorization can be revoked, in writing, at any time.

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## Authorization of Release of Medical Information through E-mail

I, ____________________________________________, authorize Kallgren Dermatology Clinic to share my medical information with me via email to my e-mail address:

_________________________________________________________________.

Medical information can include pathology results, blood/culture results, treatment options, billing information, and any other medical information that would normally be discussed over the phone. I understand that this form of communication is not always secure, as defined by the Legal Disclaimer:

**Information contained in this e-mail, including any files or photographs transmitted with it may contain confidential medical or business information intended only for use by the intended recipient(s). This message and any attachment(s) may not be used, reviewed, copied, published, disseminated, redistributed or forwarded the express written permission from Diane L. Kallgren M.D. Any unauthorized disclosure, use copying, distribution, or taking of any action based on the contents of the e-mail is strictly prohibited. Review by any individual other than the intended recipient does not waive or surrender the physician-patient privilege or any other legal rights. If you received this e-mail in error please notify the sender by return e-mail, destroy any and all copies of this message and attachment(s) and delete them from your system.**

Printed Name______________________________________________Date______________

Signature__________________________________________________

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## Office Credit Card Charges

As our patient, you have our commitment to provide you and your family with quality care and services. As your healthcare provider we need your commitment to provide prompt payment for our services.

As a courtesy to you we will bill your insurance company for the services rendered today. We request to hold your credit card information on file as a deposit for your service. Your card will be automatically charged only after your insurance company has processed your claim.

All charges that are not covered by insurance, including co-pays, deductibles and co-insurance will be charged to your credit card. Co-pays are due at the time of service.

Please contact our Billing/Collections representative with any questions at 303-444-8100.

I hereby authorize Kallgren Dermatology Clinic, PC to charge any outstanding balances to the following credit card or HSA/FSA card.

PATIENT NAME:

______________________________________________________________________________

Visa Mastercard Discover Amex

Card
Number:____________________________________________________________________

Expiration Date: ________________________ Security Code ___________

Card Holder Name (PRINT)

______________________________________________________________________________

Signature ________________________________________________________

Date:_________________________

JAN 2015