Kallgren Dermatology Clinic
3434 47th St. Suite 200 Boulder, CO 80301
Phone 303-444-8100 Email kallgrenderm@comcast.net

Patient Registration Form

Name_____

Address_____

ZIP Code_____City_____State _____

Date of Birth_____ SSN _____

Primary Phone _____Type: Circle One: Home Cell Business

Secondary Phone _____Type: Circle One: Home Cell Business

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

Employment Status: Circle One: Employed Not Employed Retired Student

Employer_____Phone_____

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 Physician (PCP)_____

Preferred Pharmacy Location_____

Primary Insurance Company_____

Member # _____ Group #_____
Name of Primary Insured_____ Date of Birth _____
Address of Primary Insured_____
City_____ State_____ ZIP_____ Phone Number_____

Secondary Insurance Company_____

Member # _____ Group #_____
Name of Primary Insured_____ Date of Birth _____

By signing below, I acknowledge that the above information is correct. I am also authorizing the billing of the above-mentioned insurance company(s).

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:

__ Anxiety
__ Arthritis
__ Asthma
__ Atrial Fibrillation (Irregular Heartbeat)
__ Bone Marrow Transplant
__ BPH (Enlarged Prostate)
__ Breast Cancer
__ Colon Cancer
__ COPD
__ Coronary Artery Disease
__ Depression
__ Diabetes
__ End Stage Renal Disease
__ GERD
__ Hearing Loss
__ Hepatitis
__ Hypertension
__ HIV / AIDS
__ Hypercholesterolemia
__ Hyperthyroidism
__ Hypothyroidism
__ Leukemia
__ Lung Cancer
__ Lymphoma
__ Prostate Cancer
__ Radiation Treatment
__ Seizures
__ Stroke

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 or have you used tanning beds? YES or NO

Do you have problems with healing? YES or NO

Do you bleed easily? YES or NO

Do you develop skin rashes in reaction to any of the following? (Please circle if YES):
Medication, Food, Environment, Bandages, Topical Neosporin, Other _____

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? YES or NO
How much per day? ____ less than 1 drink ___1-2 drinks ____3 or more drinks

Do you use recreational/illicit drugs? YES or NO
If YES, what? _____ How often? _____

What is your occupation? _____

Hobbies?_____

Patient signature (parent/legal guardian signature if patient under 18):

_____

Reviewed by: **Date:**

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Financial Policy/Patient Waiver Agreement

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.

____ **No Insurance card** - I understand if I don't produce a valid insurance card within (5) business days of my appointment I will be financially 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 financially liable for the full amount of any and all 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 hold your insurance company financially responsible for your visit. I understand that I will be financially liable for the full amount of any and all direct and/or ancillary charges related to this visit.

____ **Medicare** - I understand that Kallgren Dermatology will file claims on my behalf and 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.

____ **No Insurance** – I certify that I do not have medical insurance coverage of any kind, including Medicaid, and I am responsible for all charges due to me at time of my appointment.

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 FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED BY KALLGREN DERMATOLOGY CLINIC. IF IT IS NECESSARY FOR KALLGREN DERMATOLOGY CLINIC TO EMPLOY ANYONE, INCLUDING ATTORNEYS, TO COLLECT SUCH PAYMENTS, THEN I SHALL BE RESPONSIBLE TO PAY REASONABLE FEES AND COSTS IN ADDITION TO SAID PAYMENT.

Patient Name (PRINT)

_____

Patient Signature (Parent if a minor) Date

_____ _____

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Receipt of Notice of Patient Privacy Practices (HIPAA)

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

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

_____

_____

_____

_____

_____

Patient Signature (Parent if minor) Date

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

Kallgren Dermatology Clinic
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Portal Link: https://modernizingmedicine.force.com/customerportal/login

Customer/Patient Portal Authorization Form

By providing my email address I authorize Kallgren Dermatology Clinic P.C. to initiate the setting up of a Customer/Patient Portal through Modernizing Medicine in order to share my medical information with me.

My e-mail address is:

_____

I understand that I will receive an e-mail from Modernizing Medicine prompting me to click on the attached link and then verify my identity by confirming my last name and date of birth. Once my identity has been confirmed I will be asked to select a password.

The Modernizing Medicine Customer Portal is a convenient and secure health management tool you can use anywhere you have access to the Internet. Through the patient portal you will be able to:

- Message your provider on non-urgent health issues
- Request appointments electronically
- Request prescription refills
- View laboratory results and other important parts of your medical record
- Update your demographic information

We will continue to contact you by telephone regarding appointment reminders and test results.

Printed Name_____Date_____

Signature_____

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Credit Card on File Authorization

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

As a courtesy to you, we will bill your insurance company for the services you received today. We request to have 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 office with any questions at 303-444-8100 or kallgrenderm@comcast.net.

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

Patient Name:

_____

Visa Mastercard Discover Amex

Card Number: _____

Expiration Date: _____ Security Code (CVV): _____

Card Holder Name (PRINT)

_____

Signature _____ Date_____