

Patient Registration Form

Patient's Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

ZIP Code \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Date of Birth mm/dd/yy \_\_\_\_\_ SSN \_\_\_\_\_

Email Address \_\_\_\_\_

Primary Phone \_\_\_\_\_ Select One  Home  Cell  Business

Secondary Phone \_\_\_\_\_ Select One  Home  Cell  Business

Gender, Select One:  Male  Female  Other

Marital Status, Select One:  Single  Married  Widowed  Domestic Partner

Employment Status, Select One:  Employed  Not Employed  Retired  Student

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to Emergency Contact \_\_\_\_\_

May we leave personal medical information on your answering machine or cell phone?  Yes  No

Primary Care Physician (PCP) \_\_\_\_\_

Preferred Pharmacy Location \_\_\_\_\_

Primary Insurance Company \_\_\_\_\_

Member ID# \_\_\_\_\_ Group# \_\_\_\_\_

Name of Primary Insured \_\_\_\_\_ Date of Birth mm/dd/yy \_\_\_\_\_

Address of Primary Insured \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Phone Number \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_

Member ID# \_\_\_\_\_ Group# \_\_\_\_\_

Name of Primary Insured \_\_\_\_\_ Date of Birth mm/dd/yy \_\_\_\_\_

Address of Primary Insured \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Phone Number \_\_\_\_\_

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 dd/mm/yy \_\_\_\_\_

**Kallgren Dermatology Clinic**  
3434 47th St. Suite 200 Boulder, CO 80301  
Phone 303-444-8100 Email [kallgrenderm@comcast.net](mailto:kallgrenderm@comcast.net)

**Medical History Form**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
mm / dd / yy mm / dd / yy

Reason for today's visit:  
\_\_\_\_\_

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

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

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: \_\_\_\_\_  
mm / dd / yy

**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 check 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:

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**Allergies:**

Are you allergic to any medications?  YES or  NO

If yes, please list medications and your reaction:

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**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):**

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Reviewed by:

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

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\_\_\_\_\_  
Patient Signature (Parent if minor)

\_\_\_\_\_  
Date mm/dd/yy

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

**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 coverage and benefits are best directed to and answered by your insurance company.

Check all of the following options that apply, should none apply simply date and sign at the bottom line.

- 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 a 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 the 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

\_\_\_\_\_

\_\_\_\_\_

mm / dd / yy

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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](mailto: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 \_\_\_\_\_

dd / mm / yy