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

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_____

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Medical History Form

Name: _____ DOB: _____ (mm / dd / yy) Today's Date: _____ (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:

- ☐ 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: _____ (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:

_____
_____
_____
_____

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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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 mm/dd/yy

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

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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 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 admin@kallgrenderm.com.

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