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
__ Pacemaker
__ 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:

_____

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 FOR MEDICARE PATIENTS

We are a Medicare participating provider. We will bill Medicare and Medigap carriers. As a Medicare patient you will be responsible for payment of the following, at the time of service.

A. Any co-payments of secondary insurance

B. Any charges for non-covered or cosmetic services

You will be required to sign a waiver of liability form in the event a service is provided which is not covered by Medicare.

If you have Medicare as well as a secondary coverage with a commercial plan that is not Medigap or is an insurance company with which we have no contract with we will collect co-payment at the time the service was rendered.

Medigap is a Medicare supplemental policy offered by private insurance carriers to supplement "covered" services through Medicare. Medicare will "crossover" insurance claims to private insurers when the Medigap policy is in force. *NOTE* Not all secondary insurance policies are Medigap. Please check with your Insurance carrier if you have questions regarding your secondary insurance.

Presently we are contracted with several HMO/PPO companies. If you have a question concerning your insurance coverage, please contact your insurance company with any questions. If it is one we are contracted with we will file your claim as a courtesy to you. However, if no payment is received from your secondary supplemental policy within 60 days of filing your claim, you will be mailed a bill and be responsible to remit your balance due. If you do not have a secondary plan listed above, we will collect the 20% of allowed charges and the deductible if applicable. You will then receive a receipt to send to your secondary insurance policy with your Explanation of Benefits (EOB) when received.

Your signature below signifies that you have read and understand our Medicare Financial Policy and your responsibility regarding charges incurred at Kallgren Dermatology Clinic.

Patient Signature **Date**

_____

I request authorized Medigap benefits be made on my behalf for any services rendered. I authorize any holder of medical information to release to the Medigap carrier any information needed to determine benefits payable for related services.

Patient Signature **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_____