NAME:_____ DATE: _____
Last First Middle

PHONE: (H)_____ (W)_____ (C) _____

BILLING ADDRESS: _____
Street Address City State Zip Code

DATE OF BIRTH:_____/_____/_____ AGE:_____SSN:_____SEX: M☐ F☐

IS IT OK TO CONTACT VIA EMAIL? ☐ Yes ☐ No Email Address: _____

☐ Married ☐ Single ☐ Widowed ☐ Divorced SPOUSE NAME: _____

EMPLOYER: _____ ☐ Retired ☐ Not Employed/Stay at Home ☐ Student

PRIMARY CARE PHYSICIAN: _____ *REFERRED BY*: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: _____

May we leave a message about medical issues on voicemail or a home answering machine? ☐ Yes ☐ No

May we leave a message for you at work to call us? ☐ Yes ☐ No

May we discuss your medical condition with another person? ☐ Yes ☐ No

If yes, whom? _____ **Relationship:** _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES AND NOTICE OF NON-DISCRIMINATION: My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Privacy Practices and Notice of Non-Discrimination.

PATIENT OR RESPONSIBLE PARTY _____ **DATE:** _____

PAYMENT POLICY: I will be responsible for paying my annual deductibles, copayment and charges for any non-covered medical and cosmetic services at time of service. I understand that I am responsible for any deductibles, coinsurance, co-pays and services deemed not medically necessary by my insurance carrier.

- **I understand that if I do not show up for my scheduled appointment or do not call within 24 hours to reschedule, I will be assessed a $25.00 no show fee.**
- **I further understand that if I present a check that is returned to FRDA for insufficient funds, I will be assessed at $45.00 insufficient funds fee.**

PATIENT OR RESPONSIBLE PARTY _____ **DATE:** _____

FRONT RANGE DERMATOLOGY ASSOCIATES

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