vail | aspen | breckenridge | glenwood dermatology

PATIENT REGISTRATION FORM

Patient Name: _____ Date of Birth: _____

Age: _____ Gender: _____ Preferred Language: _____ Social Security Number: _____

Race: (Please circle one)	Ethnic Group: (Please circle one)
*Not Hispanic / Latino *Hispanic / Latino *Unknown *Other: _____ *Declined to Specify	*American Indian *African American *White *Other: _____ *Declined to Specify

How did you hear about us? _____

PHONE # (Cell) _____

PHONE # (Home)_____

May we send you appointment reminders via text message?
(Circle one): YES / NO

Please list your EMAIL so we may enable your patient portal:

_____

BILLING ADDRESS:

_____
Street/ PO Box

_____
City, State, Zip Code

Emergency Contact Information:

_____/_____/_____
Name Relationship to Patient Phone Number

Insurance Information:

_____/_____/_____
Insurance Carrier (Primary and Secondary) Name of Insured (Guarantor) Guarantor Date of Birth

Provider Information (If applicable):

_____/_____/_____
Primary Care Physician Referring Physician Name Phone Number

Release: I hereby consent Bella Derma Professional LLC to the release of information provided to or generated by Bella Derma Professional LLC to my primary care/referring physician, physical therapist, attorney, insurance carrier(s), agency or other party with a bonafide, pertinent interest via verbal consent, written, or fax/email communication. A copy or scanned image of my signature shall be valid as the original. Assignment: I hereby assign medical benefits otherwise payable to me to Bella Derma Professional LLC. I understand and agree I am financially responsible for any unpaid balance for services rendered along with legal fees incurred in collecting payment from me. If applicable: I understand I am responsible for all copayments, deductibles, co-insurance and balances payable to Bella Derma LLC. Verification: I hereby verify that all the above information is true and correct as of the date signed below. Privacy Notice: I hereby acknowledge that I have received a copy of Bella Derma Professional LLC DBA vail | aspen | breckenridge dermatology, Notice of Privacy Practices.

_____/_____
Patient Signature Date of Signature