Aesethetic Surgery & Dermatology of Cherry Creek

Patient Information Form

Name (Legal) ______________________________ Today's Date: ______________
First MI Last

Home Phone ____________________

Preferred (Nick) Name ________________________

Cell Phone ____________________

Street Address ______________________________

E-mail ________________________

City ____________ State _____ Zip ______

Race (circle)*	**Ethnicity** (circle)	**Language Preferred** (circle)
American Indian	Hispanic/Latino	English
Asian	Not Hispanic/Latino	Spanish
Black	Prefer not to answer	Other ________
White		
Other		

**data collection and classifications from Centers for Medicare & Medicaid Services (CMS)*

Marital Status: ______________________

Significant other: ______________________

Social Security #: ______________________ Birthdate __________ Age ______ Sex (Circle) F M

Employer & Occupation: ____

Person responsible for account ________________________ Phone # __________________

In case of emergency who should be notified ______________ Phone # ________ Relationship______

Primary Insurance OR Self Pay

Insurance Company ________________________________ SELF PAY ________

Additional Insurance Is patient covered by additional Insurance? No Yes

Insurance Company ________________________________

Preferred Pharmacy (REQUIRED): *If you do not have a regular pharmacy, please choose the most convenient for any Rx which may be sent during your upcoming visit, i.e. a location at which you regularly shop.*

Name: ____

City ______________________ State ______ Zip _______ Phone ______________

Have you been seen in our office previously? No ☐ Yes ☐ Last visit (mo/yr) ________________

How did you hear about our office? ____

Primary Care Physician ________________________ Phone # __________ Last visit (mo/yr) ___

Did another Doctor recommend/refer you see a Dermatologist? No ☐ Yes ☐

If yes, referring Doctor ________________________ Phone #________________________

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Authorization and Release (Please READ AND INITIAL each line and sign at the bottom)

1. *Initial*______ I hereby acknowledge receipt of Aesthetic Surgery & Dermatology's Notice of Privacy Practices.
2. *Initial*______ Late/Cancellation/No Show policy: To better serve our patients, we ask that if you are going to be more than 10 minutes late, please call use to ensure that we can still work you into our schedule. If you need to cancel or reschedule an appointment, we ask that you call 24 hour prior to your appointment. Failure to cancel or reschedule for a surgery or procedure 24 hour or more prior to appointment, you may be charged.
3. *Initial*______ I am responsible for payment in full at time of service unless previous arrangements have been made.
4. *Initial*______ I hereby authorize the release of medical information to my insurance carrier that may be necessary to process my claim, and to any other facility or Doctor involved in my care.
5. *Initial*______ I hereby authorize payment directly to Aesthetic Surgery & Dermatology for my medical expenses.
6. *Initial*______ In the event it is necessary to refer this account to collections, I/we agree to pay all costs of collection including but not limited to reasonable attorney fees, court costs and interest permitted by law.
7. *Initial*______ If my insurance company denies payment, I agree to be personally and fully responsible for any of the remaining balance.
8. *Initial*______ I understand that photographs taken during my visit(s) may be used in the following manners:
    a. To illustrate the medical procedure and demonstration of benefits;
    b. To use, publish & copyright the same in whole or in part, individually or in conjunction with, other photographs, in any medium for any purpose including art, illustration, promotion, advertising or trade, in their name or any other name that they may chose;
    c. It is also understood that the use of the photographs will in no way reveal my identity.

    I hereby release Aesthetic Surgery & Dermatology, and any of its agents from any and all claims and demands arising out of, or in conjunctions with, the use of the photographs.
9. *Initial*______ I authorize this facility to contact the patient, or authorized representative or guardian with any necessary medical information through telephone, fax or other communication.

I hereby verify above information above is accurate and complete.

X____ Relationship to Patient _____________ Date ________

Signature of Patient, Parent /Guardian or Personal Representative