

Aesthetic Surgery & Dermatology
of Cherry Creek
Patient Information Form

Name (Legal) _____
 First MI Last

Today's Date: _____

Preferred (Nick) Name _____

Home Phone _____

Street Address _____

Cell Phone _____

City _____ State _____ Zip _____

E-mail _____

Marital Status: _____

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	<small>*data collection and classifications from Centers for Medicare & Medicaid Services (CMS)</small>	

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 _____
Signature of Patient, Parent /Guardian or Personal Representative

Relationship to Patient _____

Date _____