

PATIENT REGISTRATION FORM

Patient Name: _____ Date of Birth: _____

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

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