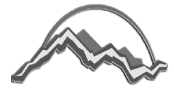


# MOUNTAIN STATE DERMATOLOGY



PATIENT NAME \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip

Home Phone (\_\_\_\_) \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex : M F

Cell Phone # (\_\_\_\_) \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_

Employer \_\_\_\_\_ Phone# \_\_\_\_\_ Marital Status: SG M W D SP

Spouse's Name \_\_\_\_\_ Best phone # to contact them: (\_\_\_\_) \_\_\_\_\_

Nearest friend or relative

Not living with you \_\_\_\_\_ Best phone # to contact them: (\_\_\_\_) \_\_\_\_\_

Reason for appointment (optional)

Referring Physician

GUARANTOR NAME \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip

Home Phone (\_\_\_\_) \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex : M F

Cell Phone # (\_\_\_\_) \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_

Employer \_\_\_\_\_ Phone# \_\_\_\_\_ Marital Status: SG M W D SP

INSURED'S NAME \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip

Home Phone (\_\_\_\_) \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex : M F

Cell Phone # (\_\_\_\_) \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_

Employer \_\_\_\_\_ Phone# \_\_\_\_\_ Marital Status: SG M W D SP

PRIMARY INS (NAME) \_\_\_\_\_ SECONDARY INS (NAME) \_\_\_\_\_

PLEASE NOTE: PAYMENT FOR SERVICES IS REQUIRED AT THE TIME OF SERVICE., AT WHICH YOUR PRIMARY INSURANCE WILL BE BILLED. INSURANCE CO-PAYMENTS AND DEDUCTIBLES MUST BE PAID WHEN SERVICES ARE RENDERED. IF YOU HAVE ANY QUESTIONS ABOUT YOUR FINANCIAL RESPONSIBILITY, PLEASE ASK A MEMBER OF OUR STAFF. THANK YOU FOR ALLOWING MOUNTAIN STATE DERMATOLOGY TO CARE FOR YOU.

ALL INFORMATION IS CONFIDENTIAL. THE FOLLOWING NOTICE IS REQUIRED AND IMPERATIVE FOR YOUR RECORDS. THIS IS A LIFETIME AUTHORIZATION UNLESS REVOKED IN WRITING.

I authorize Mountain State Dermatology and its physicians/physician assistants to diagnose and provide medical care for the above named patient. I am aware that this consent includes all procedures including treatments and surgery. I am aware that I have a surgical procedure my specimen will be sent for histopathology and I consent to the release of my information for this purpose.

☆ Patient/Guarantor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize payment of medical benefits to the above mentioned provider(s) for all services rendered. Please accept a photocopy of my signature as the original on file. I am aware that any charges not covered by my insurance are my responsibility. I authorize the release of my medical information for the processing of my claims. I understand that if I have a surgical procedure I will have additional charges for the pathology. I am aware that if I have an HMO/MC plan that I am responsible for obtaining authorizations for my visits. If I do not follow the guidelines set by my insurance company I will be fully responsible for any and all charges. I understand that I am responsible for any remaining balance. I understand that payment is due in full within 90 days of the date of my first statement (REGARDLESS OF INSURANCE) unless other financial arrangements have been made. Workers Compensation is not accepted.

☆ Patient/Guarantor Signature: \_\_\_\_\_ Date: \_\_\_\_\_