Mountain West Dermatology P.C.

2655 Little Bookcliff Drive,
Grand Junction, CO 81505
970-242-7273

Patient registration form

Instructions: Please complete all sections of this form in blue or black ink or by typing into the interactive fields if viewing online

Patient information

Name (last, first, middle initial): _____

Mailing address: _____

Street (if different from mailing address): _____

City: _____ State: _____ Zip _____

Primary phone: _____ Mobile phone: _____

Email Address: _____

Date of birth: ____/____/_____

Sex assigned at birth (choose one):

- ◯ Female
- ◯ Male
- ◯ Prefer not to say

Gender (choose one):

- ◯ Woman
- ◯ Man
- ◯ Nonbinary
- ◯ Prefer to self describe: _____

Ethnicity (choose all that apply):

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other: _____
- ☐ Prefer not to say

Preferred language:

- ☐ English
- ☐ Spanish
- ☐ Other: _____

Emergency contact

Name: _____ Relationship to patient: _____

Primary phone: _____ Mobile phone: _____

Responsible party

Only complete this section if someone other than the patient is legally or financially responsible

Name (last, first, middle initial): _____

Mailing address: _____

Street (if different from mailing address): _____

City: _____ State: _____ Zip: _____

Primary phone: _____ Mobile phone: _____

Email address: _____

Insurance

Insurance or self pay:

◯ I have insurance

◯ I am self pay

Primary insurance company: _____

ID #: _____ Group # _____

Subscriber name: _____

DOB: ___ / ___ / _____ Relationship to patient: _____

Secondary insurance company: _____

ID #: _____ Group #: _____

SSN: (if Medicare is secondary insurance) _____

If Medicare is your secondary insurance we may need your SSN for coordination of benefits.

Subscriber name: _____

DOB: ___ / ___ / _____ Relationship to patient: _____

Providers & pharmacy

Name of preferred pharmacy & location: _____

Primary care physician: _____ Referring doctor: _____

Financial responsibility and assignment of benefits

I authorize billing of my insurance and assign benefits directly to the practice. I agree to pay amounts not covered by insurance, including copays at time of service. Fees for missed or late-canceled appointments and other charges are per our posted policy available at our front desk and on our website. If a biopsy or specimen is taken, I consent to it being sent to an outside laboratory, which may be billed separately.

How we contact you

We may contact you about appointments and scheduling. Choose your preferences; you can change these at any time.

Text messages: ◯ Yes ◯ No
(Note: text messages may not be secure.)

Preferred phone for calls/voicemail: ◯ Primary number ◯ Mobile number

OK to leave a detailed voicemail? ◯ Yes ◯ No

People we may talk to about your care

I authorize the practice to share information about my care with the individuals listed below:

Name: _____

Relationship to patient: _____ Phone: _____

Name: _____

Relationship to patient: _____ Phone: _____

Clinical photography for your medical record

I consent to clinical photos being taken to treat and document skin conditions. These images will become part of my secure, HIPAA-protected medical record.

HIPAA notice acknowledgment

I received or was offered the practice's Notice of privacy practices. It is available at the front desk and on our website.

Signature

By signing below, I confirm that the information I provided on the registration form is true and complete to the best of my knowledge. I consent to receive evaluation and treatment as recommended by my clinician, and I understand I may ask questions and revoke this consent at any time.
I acknowledge and agree to the consents and acknowledgments listed above.

Patient or responsible party signature: _____ Date: ___ / ___ / _____

(if signed by responsible party, please print name and relationship) _____