# Patient Registration Information

***Please PRINT and complete ALL sections below of ALL Forms***

Last Name: _____ First Name: _____ Middle Initial: _____ Nickname: _____

Birth/Maiden Name: _____ Gender: □ Male □ Female

Marital Status: □ Single □ Married □ Divorced □ Widowed Date of Birth: _____

**Please Circle Race**: Asian, Black or African American, Hispanic, White, Other_____ ☐ Declined

**Please Circle Ethnic Group:** Hispanic/Latino or Non Hispanic/Latino

**Preferred Language Spoken**: _____

Address: _____

_____

Home #:_____ Cell #: _____ Work #:_____ Email: _____

**(Please circle above your preferred method of contact)**

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**Patient's Insurance Information:**

Name of insured person: _____ Insured Person Date of Birth: _____

Relationship to patient ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other _____

Name of Insurance:_____

Policy Number:_____ Group Number:_____

Mailing Address:_____

_____

***Self-Pay Patients:** If you are a self-pay patient, payment is expected in full at the time of the visit.

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**Patient's Primary Care Physician:** We need Providers Name, not the practice name. Thank you.

Name: _____

Address: _____

Phone #: _____ Fax #: _____

**Emergency Contact:**

Name: _____ Relationship: _____

Address: _____

_____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

## Patient Registration Information

***Please PRINT and complete ALL sections below***

- **Permission to Discuss Patient Information with Others**

I give Denver Tech Dermatology Associates, P.C. permission to leave detailed messages at my home phone number, cell phone number or by Patient Portal regarding any tests that I may incur here as a patient (for example, biopsy results, blood results, or other test results).

**Please Circle:** **Yes** **No**

**Please list others who have permission to receive your test results should you be unavailable (i.e. children, parents, spouse).**

_____ _____

Name of other person to receive messages Relationship to Patient

_____ _____

Signature Date

***If you do not want information shared with anyone else, please complete the section below:***

- **Results to be Given to Patient Only**

Complete only if you do not want anyone but yourself to receive results.

Please leave a message at _____for me to return your call.

Signature: _____ Date: _____

## Acknowledgement of Notice of Privacy Practices (HIPAA)

I hereby acknowledge that I have received the Notice of Privacy Practices of Denver Tech Dermatology Associates, P.C. and I have been given an opportunity to receive a printed copy to take with me if I choose to do so.

This form is also available on our web site at www.DTCderm.com.

**Signature: _____** **Date: _____**

**Denver Tech Dermatology Associates, PC**
**5889 Greenwood Plaza Blvd, Suite 250**

**Phone: 303-222-9559**
**Fax: 303-222-9557**

**12-2019**