# Alta Vista Dermatology

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Highlands Ranch, CO 80129

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## *Patient Information*

Please Print

Today's Date ____/____/____

Patient Name _____ Sex ☐ F ☐ M Date of Birth ____/____/____
*Last, First, Initial*

Address _____

City _____ State _____ Zipcode _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____ Sign up to receive newsletters/promotions? ☐ Y ☐ N

In Case of Emergency:

Who should be notified _____ Phone _____ Relation to Patient _____

If visiting from out of town, please provide local phone number _____

## *Optional Demographics*

☐ Decline all

Primary Language ☐ English ☐ French ☐ Spanish ☐ Chinese ☐ Other _____

Race ☐ American Indian ☐ Asian ☐ Unknown ☐ African American ☐ White ☐ Other

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

## *How Did You Find Us?*

Referring Physician _____ Group/Practice Name _____

Primary Physician (if different) _____ Health Insurance ☐ Web Search ☐ Other _____

## *Primary Insurance*

Insurance Provider _____ Subscriber Name _____
*Last, First, Initial*

Subscriber Date of Birth ____/____/____ Subscriber SSN ___ – ___ – ____ Relation to Patient _____

Address (if different) _____

City _____ State _____ Zipcode _____

Home Phone _____ Cell Phone _____ Work Phone _____

## *Secondary Insurance*

Insurance Provider _____ Subscriber Name _____
*Last, First, Initial*

I affirm the information provided above and for the purpose of this health visit is the most recent and current information pertaining to contact information and health insurance. I understand it is my responsibility to notify Alta Vista Dermatology of any changes in contact information and health insurance provider.

_____ _____
*Signature of Patient or Legal Representative* *Date*