SkinCare Colorado
4545 East 9th Avenue, Suite 420
Denver, CO 80220
303-586-7769

Patient Information

Date: ________________________

Patient's Name:______________________________ Gender: _______ Date of Birth: ________________

Address:____ State: __________ Zip:_____________

Home Phone: ____________________________ Cell Phone: ____________________________

Emergency Contact: ____________________________________ Phone: ___________________________

Pharmacy / Phone: _________________________________ Email*:_______________________________

*By providing your email address you are granting permission to receive quarterly newsletters.

☐ No, I do not wish to receive quarterly email newsletters.

Race: _____________________________ Ethnicity: _______________________________

Insurance Information (Primary)

Insurance Company: ________________________________ Phone Number: ______________________

Member's Name: _________________________________ Date of Birth: __________________________

Member's ID: ____ Group #: _________________________

Self: __________ Spouse: __________ Child / Dependent: ___________ Co-pay: $________________

Primary Care Doctor: ____

DO YOU HAVE SECONDARY INSURANCE: ☐ YES ☐ NO

*IF NOT PROVIDED AT TIME OF VISIT, YOU WILL BE RESPONSIBLE FOR AMOUNT OTHERWISE COVERED BY SECONDARY INSURANCE.

____ ___________________________

Patient, Insured, or Beneficiary Signature Date