Welcome To Our Office

PATIENT INFORMATION FORM

Please fill out completely

Name of Patient: _____
First Middle Last

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Date of Birth: _____ **Age:** _____ **Sex:** _____ **Social Security Number:** _____

Employer: _____ **Occupation:** _____

Employer Address: _____ May we contact you at work? (Circle) Yes No

Emergency Contact: Name: _____ **Relationship:** _____

Home Phone: _____ **Work Phone:** _____

Who referred you to our office?

Name: _____ **Phone:** _____

Primary Care Physician

Name: _____ **Phone:** _____

****To avoid error or delay in the processing of your insurance claim, the following section must be filled out completely.****

PRIMARY INSURANCE COMPANY

Name: _____

Member ID Number: _____

Group Number: _____ **Copay:** _____

Name of Insured (employee): _____

Employer: _____

Employer Phone: _____

Insured's Social Security: _____

Insured's Date of Birth: _____

SECONDARY INSURANCE COMPANY

Name: _____

Member ID Number: _____

Group Number: _____ **Copay:** _____

Name of Insured (employee): _____

Employer: _____

Employer Phone: _____

Insured's Social Security: _____

Insured's Date of Birth: _____

Accident Related? ☐ Yes ☐ No if yes ☐ Auto ☐ Work Comp ☐ Other Date of Accident: _____

It is my responsibility to pay any copayment, deductible amount, co-insurance or any other balance not paid by my insurance.
I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and other health plans to: **Front Range Surgical Associates**. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, whether paid or not paid, by my insurance. I hereby authorize said assignee to release all information, including medical history and medical records, to my insurance company.

_____ _____
PATIENT SIGNATURE **DATE**

Update: _____