ALLERGY & ASTHMA CENTER OF THE ROCKIES DEMOGRAPHIC FORM

PATIENT INFORMATION:	
PATIENT NAME:	DATE OF BIRTH:
NICKNAME:	SOCIAL SECURITY:
GENDER: MALE FEMALE	MARITAL STATUS: M S D W
HOME ADDRESS:	
CONTACT NUMBER HOME:	
CONTACT NUMBER CELL:	
CONTACT NUMBER WORK:	
EMPLOYER NAME & ADDRESS:	
OCCUPATION:	
PRIMARY CARE PHYSICIAN:	
REFERRING PHYSICIAN:	
Text Reminder:____Yes ____No	Please list phone number for texted reminders:
INSURANCE:	
NAME OF POLICY HOLDER:	POLICY HOLDER DATE OF BIRTH:
ID:	GROUP #:
RELATIONSHIP TO PATIENT:	PHONE # OF POLICY HOLDER:
SOCIAL SECURITY # OF POLICY HOLDER:	
ADDRESS:	
PARENT/GUARDIAN/EMERGENCY CONTACT:	
1. NAME:	
DATE OF BIRTH:	
RELATIONSHIP TO PATIENT:	
CONTACT NUMBER:	
ADDRESS:	

GOVERNMENT REQUIREMENT: (PLEASE CIRCLE)	**HOW DID YOU HEAR ABOUT US? (PLEASE CIRCLE)**
AFRICAN	FRIEND
ALASKAN NATIVE	INSURANCE
AMERICAN INDIAN	VALPAK
ASIAN	NEWSPAPER
CAUCASIAN	DOCTOR
LATINO	INTERNET
	OTHER

ASSIGNMENT OF BENEFITS: I authorize Medicare and/or any other insurance plans under which I am covered to make payment to Allergy and Asthma Center of the Rockies or its Assignee of authorized benefits on my behalf, for products or services furnished to me. I understand that by signing this agreement, I accept financial responsibility for the deductible, co-insurance, co-payments and all non-covered charges.

RELEASE OF INFORMATION: I authorize the release of any medical or other information necessary to verify benefits, process claims, or provider appropriate care of related services provided by Allergy and Asthma Center of the Rockies or its Agents. I acknowledge the receipt of the Privacy Practices for Allergy and Asthma Center of the Rockies.

_____ _____

Signature **Date**

_____ _____

Printed Name **Date of Birth**