FRONT RANGE Endocrinology

Patient Information Sheet

Please print information requested. Form must be complete in order for us to set up your records before the doctor sees you

PATIENT

Name: _____ Last _____ First: _____ M.I. _____ nickname _____

SSN: _____ Maiden or Former Name (If Applicable) _____

Sex: M F Date of Birth _____ Marital Status S M D W Sep

Home Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____ Yrs Employ: _____

Business Address: _____

City: _____ State: _____ Zip: _____

E-Mail Address: _____ Primary Care Physician: _____

RESPONSIBLE PARTY

Name: _____ Last _____ First: _____ M.I. _____ nickname _____

SSN: _____ Maiden or Former Name (If Applicable) _____

Sex: M F Date of Birth _____ Marital Status S M D W Sep

Relationship to Patient: _____

Home Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____ Yrs Employ: _____

Business Address: _____

City: _____ State: _____ Zip: _____

E-Mail Address: _____ Primary Care Physician: _____

Emergency Contact

Nearest Relative NOT Living With You

Name: _____

Address: _____

Hm Phone: _____ Wk Phone: _____

PAYMENTS (INCLUDING INSURANCE AND CO-PAYMENTS) ARE DUE AT THE TIME OF SERVICE

INSURANCE

INSURANCE INFORMATION

PRIMARY CARRIER: _____

ID # _____

Group No: _____ Copay Amt $ _____

Coverage: Spouse ❑ Dependent ❑

SECONDARY CARRIER: _____

ID # _____

Group No: _____ Copay Amt $ _____

Coverage: Spouse ❑ Dependent ❑

STAFF

Arrived: _____ Appt Time: _____ Entered into System: _____ EMR No. _____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT AND RELEASE OF MEDICAL INFORMATION

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I understand that all charges are due and payable at the time of service. I am also aware that if insurance does not cover services, I am responsible for all charges. Also, I understand that Front Range Endocrinology, P.C. reserves the right to charge and collect $25.00 for any missed appointment without cancellation I understand that a $5.00 rebilling fee will be added to all charges billed to me that are 55 day or older. I authorize payment of insurance benefits directly to Front Range Endocrinology, P.C. I authorize release of medical information needed to complete insurance company claim inquiries, quality assurance, and utilization management activities.

Signature: _____ Date: _____

Responsible Party Staff Init