

ORTHOPAEDIC PHYSICIANS OF COLORADO

PATIENT INFORMATION Please Print

Today's Date _____

Name _____ Phone (____) _____
First Middle Last Home

Address _____
Street Apt# City State Zip

Employer _____ Occupation _____ Phone (____) _____

SS# _____ DOB _____ Age _____ Male Female Marital Status: S M W D

Parent/Spouse Name _____ SS# _____

Parent/Spouse Employer _____ Phone (____) _____

Reason for today's visit: _____

Friend or Relative
not living at your home _____ Phone (____) _____

Family Doctor _____ Address _____

Referring Doctor _____ Address _____

Accident Information

Date of injury _____ Was injury/accident due to: ___W/C? ___Auto? ___Other?

Please describe: _____

HEALTH INSURANCE INFORMATION

Primary Insurance

Company _____ Policy # _____ Group # _____

Address _____ Phone (____) _____
Address City State Zip

Insured's Name _____ Relationship to Patient: Self Spouse Child Other
First MI Last

Insured's SS# _____ Insured's DOB _____ Insured's Sex Male Female

NOTE: If you choose not to provide insured's SS# and the claim is subsequently denied for missing information, you may be held financially responsible for your charges.

I acknowledge, have read and understand, and agree to the statement above. Please initial here: _____

Secondary Insurance

Company _____ Policy # _____ Group # _____

Address _____ Phone (____) _____
Address City State Zip

Insured's Name _____ Relationship to Patient: Self Spouse Child Other
First MI Last Please Circle

Insured's SS# _____ Insured's DOB _____ Insured's Sex Male Female

Assignment of Benefits and Release of Information Statement

I grant permission to Orthopaedic Physicians of Colorado, P.C. to release any pertinent information to the above insurance company/companies upon request, and I also authorize payment directly to Orthopaedic Physicians of Colorado, P.C. for medical services rendered as described herein. I understand that I am financially responsible for those charges not paid by my insurance. I hereby acknowledge that I consent to usage of my protected healthcare information as described on the reverse of this form.

Signature: _____ Date _____