

# 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 \_\_\_\_\_