

## Patient Demographics – Page 1

Patient Information			
Patient First Name:		Last Name:	
Nickname:	Race: <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native		Ethnicity: <input type="checkbox"/> Hispanic or Latino
Language Preference:	<input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Refuse to Report		<input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Refuse to Report
Date of Birth:	SSN:	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Address:		State:	Zip:
Primary Contact Phone:		Name/Relation to patient at this number:	
Primary Email Address:			
Secondary Contact Phone:		Name/Relation to patient at this number:	
Emergency Contact Name:		Phone:	Relationship to Patient:

Parent / Guardian Information – Financial Responsibility			
Primary Guarantor's Name:		SS#:	DOB:
Relationship to Patient: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Step-Father <input type="checkbox"/> Step-Mother <input type="checkbox"/> Legal Guardian			
Address:		City	State: Zip:
Cell Phone:		Employer / Occupation:	
Home Phone:		Work Phone:	
Secondary Guarantor's Name:		SS#:	DOB:
Relationship to Patient: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Step-Father <input type="checkbox"/> Step-Mother <input type="checkbox"/> Legal Guardian			
Address:		City	State: Zip:
Cell Phone:		Employer / Occupation:	

Primary Care Physician – Referring Physician			
Practice Name		Physician Name	
Phone:		Fax	
Address	City	State	Zip

## Patient Demographics – Page 2

Insurance Information			
Primary Insurance Company		Secondary Insurance Company	
Insurance Address		Insurance Address	
ID#		ID#	
Group # or Name		Group # or Name	
Subscriber Name		Subscriber Name	
Subscriber DOB		Subscriber DOB	
Relationship to Patient		Relationship to Patient	
Employer		Employer	

How can we contact you?				
Type of call	Name	Phone number	OK to leave a detailed message?	
			YES	NO
Appointment Reminders:	#1			
	#2			
Medical Information:	#1			
	#2			

Pharmacy & Laboratory Information	
Pharmacy Name: Phone and/or cross streets:	Preferred Lab:

How did you hear about us?		
<input type="checkbox"/> Family / Friends?	<input type="checkbox"/> Insurance Directory?	<input type="checkbox"/> Other Practice / Physician Listing?
<input type="checkbox"/> Follow-up from recent hospital visit: <input type="checkbox"/> Rocky Mountain Hospital for Children / Presbyterian St. Luke's Medical Center		
<input type="checkbox"/> Sky Ridge Medical Center	<input type="checkbox"/> Rose Medical Center	<input type="checkbox"/> Other _____

*We bill directly to your insurance as a courtesy to you. However, it is your responsibility to understand your benefits, and eligibility. You are ultimately responsible for payment if your visit is not covered. If you need further information, please contact your insurance carrier directly using the customer service phone number on the back of your card. Please be prepared to make a payment or co-payment at the time of service.*

***By signing below I affirm that all information above is true and correct to the best of my knowledge.***

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date