Rocky Mountain Pediatric Infectious Disease Consultants
HealthONE

Patient Demographics – Page 1

Patient Information

Patient First Name:		Last Name:	
Nickname: Language Preference:	Race: ___ White ___ Black or African American ___ American Indian or Alaska Native ___ Asian ___ Native Hawaiian or Other Pacific Islander ___ Refuse to Report	Ethnicity: ___Hispanic or Latino ___Not Hispanic or Latino ___ Refuse to Report	
Date of Birth:	**SSN:**	Male ☐	Female ☐
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: ☐Father ☐Mother ☐Step-Father ☐Step-Mother ☐Legal Guardian			
Address:	City	State:	Zip:
Cell Phone:	Employer / Occupation:		
Home Phone:	Work Phone:		
Secondary Guarantor's Name:	SS#:	DOB:	
Relationship to Patient: ☐Father ☐Mother ☐Step-Father ☐Step-Mother ☐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

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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?

☐ Family / Friends? ☐ Insurance Directory? ☐ Other Practice / Physician Listing?

☐ Follow-up from recent hospital visit: ☐ Rocky Mountain Hospital for Children / Presbyterian St. Luke's Medical Center

☐ Sky Ridge Medical Center ☐ Rose Medical Center ☐ 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 a make 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