ALPINE ENT

1120 East Elizabeth Street ~ Fort Collins, Co ~ (970) 221-1177

PATIENT INFORMATION

Name: _____ Patient ID #: _____ Sex: [ ] M [ ] F

Address: _____ Date of Birth: _____

_____ Social Security #: _____

City, State, Zip: _____ Marital Status: [ ] Married [ ] Single [ ] Divorced

Phone: _____[ ] Home [ ] Work [ ] Other Referring Physician: _____

Phone: _____[ ] Home [ ] Work [ ] Other Primary Physician: _____

RACE: _____ **ETHNICITY:** _____ **PRIMARY LANGUAGE:** _____

PATIENT EMPLOYMENT [ ] Employed [ ] Retired [ ] Unemployed **CONTACTS** Name, phone & Relationship i.e. Family Pharmacy etc.

Employer: _____ _____

Phone: _____ _____

Address: _____ _____

City,State,Zip: _____ _____

GUARANTOR [ ] Same as Patient **EMPLOYMENT**

Name: _____ Employer: _____

Address: _____ Phone: _____

_____ Social Security #: _____

City,State,Zip: _____ Date of Birth: _____

PRIMARY INSURANCE [ ] Same as Patient [ ] Same as Guarantor [ ] other

Insured Party: _____ Company: _____

Insured Phone: _____ Social Security #: _____

Date of Birth: _____ Insured ID: _____

Relationship to Patient: _____ Policy Group: _____

SECONDARY INSURANCE [ ] Same as Patient [ ] Same as Guarantor [ ] Other

Insured Party: _____ Company: _____

Insured Phone: _____ Social Security #: _____

Date of Birth: _____ Insured ID: _____

Relationship to Patient: _____ Policy Group: _____

Patient Signature: _____ Date: _____

Parent or Legal Guardian if Minor

Okay to leave messages at provided phone numbers? _____

It is the policy of this office to bill any balance that is deemed patient responsibility to the parent/guardian who authorized treatment.