Colorado Cardiovascular Surgical Associates, P.C.

PATIENT INFORMATION

Date of Visit:_____ Doctor you are seeing this visit:_____

Last Name:_____ **First:**_____ **Middle Initial:**_____

Street Address:_____

City/State/ZIP:_____

Home Phone:_____ Work/Cell Phone:_____

Birthdate:_____ Age:_____ Sex:_____ Marital Status:_____ SSN:_____

Emergency Contact:_____ Relationship:_____

Home Phone:_____ Work/Cell Phone:_____

Patient's Employer:_____ Address:_____

City/State/ZIP:_____ Occupation:

Referring Physician:_____ Phone:_____

Family Physician/PCP:_____ Phone:_____

Is this a Worker's Comp Claim? Yes No Incident Date:_____ Claim Number:_____

Is this from an auto accident? Yes No Incident Date:_____ Claim Number:_____

INSURANCE INFORMATION

Primary Insurance

Company:_____

Address:_____

City/State/ZIP:_____

ID Number:_____

Group/Policy Number:_____

Policyholder:_____

SSN:_____

Secondary Insurance

Company:_____

Address:_____

City/State/ZIP:_____

ID Number:_____

Group/Policy Number:

Policyholder:_____

SSN:_____

Do you have a third insurance company? Yes No

I authorize payment of medical benefits to Colorado Cardiovascular Surgical Associates, P.C. for all services rendered. I authorize to Colorado Cardiovascular Surgical Associates, P.C. to acquire or release any medical records to help in the treatment of my illness or payment of services. **I understand the financial policies of this practice and agree that I am responsible for the balance on my account for services rendered. Account balances that exceed 60 days will be charged a rebilling charge of $5.00/month.**

Patient Signature:_____ Date:_____