



# Patient Information Form

Appt Time

Appt Date

Visit Type

Provider

**Patient Info: Acct:**

**MRN:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_

SSN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Marital Status: S M W D Sep

Gender: Age: \_\_\_\_\_

Race: African American Asian Caucasian Chinese Filipino Hispanic Japanese Native American Native Hawaiian Pacific Islander Other

Ethnicity: Hispanic Non-Hispanic Unknown

Primary Language: English Spanish other: \_\_\_\_\_

Email: \_\_\_\_\_

**Guarantor Info:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Guar Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_

SSN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_

Relationship: \_\_\_\_\_

Email: \_\_\_\_\_

**Emergency Info:**

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

How did you hear about our clinic:

YELLOW PAGES

RADIO

NEWSPAPER

TELEVISION

FRIEND

INSURANCE

OTHER \_\_\_\_\_

DOCTOR

Insurance Name:

Subscriber

Group

Cert #

**Registration Comment:**

I authorize treatment of the person(s) named above and agree to pay all fees and charges for such treatment. I understand that all charges are due and payable at the time of service. I am also aware that if insurance does not cover services, or if the physician does not accept assignment, I am responsible for all charges. Also, I understand that CSHP reserves the right to charge for and collect \$50.00 for any missed appointment without cancellation. I authorize payment of insurance benefits directly to the Colorado Springs Health Partners, PC. I acknowledge and agree that any account that becomes delinquent will be subject to collections services. I also agree to pay all court costs and reasonable attorney fees for collection of all past due amounts owed.

I hereby authorize release of medical information needed to complete insurance company claim inquiries.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_