Surgical Specialists OF COLORADO

400 Indiana Street
Suite #200
Golden, CO 80401
Phone: 303-940-8200

3455 Lutheran Parkway
Suite #290
Wheat Ridge, CO 80033
Phone: 303-940-8200

200 W County Line Road1
Suite #135
Highlands Ranch, CO 80129
Phone: 303-940-8200

PATIENT INFORMATION

_____ Date of Birth _____
Last Name First Name MI

_____
Street Address City State Zip Code

Please indicate • _____ • _____
Preferred method Home Phone Cell Phone
To reach you. • _____
Work Phone

Social Security Number _____ Sex • Male € Female € Transgender € Nonbinary

Patient Status • Single • Married/partnered € Widowed € Child

Is Patient a Student? • Yes • No If Yes, Name of School _____

Preferred Language _____

RACE:

☐ Asian
☐ American Indian or Alaskan Native
☐ Pacific Islander or Hawaiian
☐ Caucasian
☐ Black or African American
☐ Unknown

ETHNICITY:

☐ Hispanic or Latino
☐ Non-Hispanic or Non-Latino
☐ Prefer not to answer

_____ _____
Occupation Employer

Email Address _____

NEXT OF KIN In case of emergency, give the name of *nearest relative* or *close friend* not living with you.

Name _____ Preferred Phone _____ Relationship _____

*If you receive a prescription for a "controlled" drug, your identifying prescription information will be entered into Colorado's electronic Prescription Drug Monitoring Database (PDMD) when the drug is dispensed to you and may be accessed for limited purposes by specific individuals.

PRIMARY CARE PHYSICIAN

Name _____ Phone _____

REFERRING PHYSICIAN

Name _____ Phone _____

Does the Patient have Health Insurance? • Yes • No

INSURANCE INFORMATION

Primary Health Insurance Name of Insurance Company _____

Policy Holders Last Name First Name MI Date of Birth

Social Security Number _____ Work Phone _____

Relationship to Patient: Self • Spouse • Child • Other • Employer _____

Primary Health Insurance (Cont)

ID/Policy # Group #

Mailing Address City/State

Additional Health Insurance Name of Insurance Company _____

Policy Holders Last Name First Name MI Date of Birth

Social Security Number _____ Work Phone _____

Employer _____

Relationship to Patient: Self • Spouse • Child • Other •

ID/Policy # Group #

Mailing Address City/State

Is this visit related to a work injury? • Yes • No If YES, Date of Injury: _____

Work Related Injury Information

Name of Workman's Comp Carrier Contact Person/Adjustor Phone

Claim # Claims Mailing Address City State Zip

Is this visit related to an automobile injury? • Yes • No If YES, Date of Accident: _____

Name of Auto Insurance Contact Person Phone

Claim # Claims Mailing Address City State Zip

PLEASE READ AND SIGN THE FINANCIAL POLICY OF SURGICAL SPECIALISTS OF COLORADO, P.C. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN PROVIDED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. PLEASE CONTACT OUR BUSINESS OFFICE TO ARRANGE PAYMENT OPTIONS OR TO DISCUSS ANY INSURANCE QUESTIONS AND/OR FINANCIAL/PAYMENT QUESTIONS YOU MAY HAVE.

I AGREE TO BE RESPONSIBLE FOR ALL PAYMENT OF SERVICES PROVIDED ON MY BEHALF OR MY DEPENDANTS. IT IS ULTIMATELY MY RESPONSIBILITY TO UNDERSTAND THE REQUIREMENTS AND PROVISIONS OF MY INSURANCE POLICY. IF A REFERRAL IS REQUIRED PRIOR TO SEEING A SPECIALIST, I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO OBTAIN ONE. THE UNDERSIGNED ASSIGNS ALL APPLICABLE INSURANCE BENEFITS/PAYMENTS TO THE PHYSICIAN/PROVIDER OF SERVICE. IT IS FURTHER UNDERSTOOD THAT THE UNDERSIGNED IS FINANCIALLY RESPONSIBLE FOR PAYMENT OF ALL SERVICES THAT ARE NOT COLLECTED AS A RESULT OF THIS ASSIGNMENT. THIS ALSO APPLIES TO NON-COVERED SERVICES PROVIDED AND/OR THE ABSENCE OF INSURANCE COVERAGE AT THE TIME OF SERVICE. I AUTHORIZE SURGICAL SPECIALISTS OF COLORADO, P.C. TO PROVIDE INFORMATION ABOUT MYSELF OR CHILD AND THE CARE GIVEN TO MY HEALTH INSURANCE COMPANY WHEN SUBMITTING REQUESTS FOR PAYMENT OF SERVICES PROVIDED TO MYSELF OR MY MINOR CHILD.

_____ I AGREE TO ALLOW MY PHOTO TO BE TAKEN, ONLY FOR THE PURPOSE OF INCLUSION IN THE SURGICAL SPECIALISTS OF COLORADO ELECTRONIC MEDICAL RECORD

_____ I DECLINE TO HAVE MY PHOTO TAKEN

_____ _____

Patient/Parent of Minor or Authorized Person Date