

SURGICAL SPECIALISTS OF COLORADO, P.C.

400 Indiana Street Suite #200 Golden, CO 80401 Phone: 303-940-8200 200 W County Line Road Suite #135 Highlands Ranch, CO 80129 Phone: 303-940-8200

PATIENT INFORMATION

	First Name			Date of Birth			
Last Name			MI				
Street Address		City	State		Zip Code		
Please indicate							
Preferred method	method Home Phone		Cell Phone				
To reach you. \Box	Work P	hone					
Social Security Number			Sex 🗆 Male	☐ Female	□ Transgender	□ Nonbinaı	
Patient Status	e □ Ma	rried/partnered	☐ Widowed	□ Child			
Is Patient a Student?	□ No	f Yes, Name of Scho	ool				
Preferred Language							
RACE: ☐ Asian ☐ American Indian or Alaskan Native ☐ Pacific Islander or Hawaiian ☐ Unknown			n American	ETHNICITY: ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino ☐ Prefer not to answer			
Occupation			Employer				
Email Address							
NEXT OF KIN In case of ea				•			
Name	ne Preferred P			one Relationship			
*If you receive a prescrip Colorado's electronic Prescri be accessed for limited purp	ption Drug	Monitoring Databas	ar identifying pro e (PDMD) when	escription in the drug is	formation will be dispensed to you	entered into and may	
PRIMARY CARE PHYSIC	IAN						
Name	ame			Phone			
REFERRING PHYSICIAN							
Name			Phone				
Does the Patient have Health	n Insurance	? □ Yes □ No					
INSURANCE INFORM Primary Health Insur		ume of Insurance	e Company				
Policy Holders Last Name	:	First Name		MI	Date of	Birth	
Social Security Number			Work F	Phone			
Relationship to Patient: Self	`□ Spouse	e □ Child □ Oth	er □ Employ	er			

Primary Health Insurance (Cont) ID/Policy# Group # City/State Mailing Address Additional Health Insurance Name of Insurance Company _____ Date of Birth Policy Holders Last Name First Name ΜI Social Security Number _____ Work Phone _____ Employer _____ Relationship to Patient: Self \square Spouse \square Child \square Other \square 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 Claims Mailing Address State Claim# City Zip Is this visit related to an automobile injury? ☐ Yes ☐ No If YES, Date of Accident:_____ Contact Person Name of Auto Insurance 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

Date

Patient/Parent of Minor or Authorized Person