Longs Peak Family Practice

PATIENT INFORMATION

First Name: ___________________________Middle Initial: _____ Last: ______________________________

Date of Birth: _________________________

Billing Address: ______________________________________ City: ____________________ ZIP: ________

Home Phone: ____________________ Cell Phone: _____________________ Work Phone: _______________

What is the best way to contact you? Home _____ Cell______ Work ______

Marital Status: S/M/D/W Spouse/Significant Other: _______________________________

Emergency Contact: ______________________________ Relationship: _______________________________

Emergency Contact Phone: _____________________

Race & Ethnicity: Caucasian: _____ Black Hispanic or Latino: _____ White Hispanic or Latino: _____

American Indian or Alaskan Native: _____ Asian: _____ African American: _____

Native Hawaiian and other Pacific Islander: _____ Refused: _____ Language Preference: _______________

How did you hear about our office? ____

Email Address: ____

May we send test results to you by email? YES/NO

Parent/ Guardian (If Patient is Under 18):

First Name: _________________________ Middle Initial_____ Last: _________________________________

Date of Birth: _________________________

Home Phone: ____________________ Cell Phone: _____________________ Work Phone: _______________

INSURANCE INFORMATION

Insurance Subscriber (**Main Policy Holder**): Name: ____

Relationship to Patient: ___________________________ Date of Birth: ______________

(Fill out if we did NOT take a copy of your Insurance Card)

Insurance Company: ____________________________________ Company Phone: ______________________

Medical Billing Address:____

Member/Subscriber Number: ___________________________ Group/Policy Number: ___________________

Assignment of Insurance Benefits

I hereby authorize Longs Peak Family Practice to recover from my insurance company, payment for any health service that is provided to me. I understand that I am financially RESPONSIBLE for ALL co-pays, co-insurance, deductibles, and non covered charges that is determined by my insurance company. I hereby authorize Longs Peak Family Practice to release all information necessary to secure such payments. A photocopy or electronic scan of this statement is to be considered as valid as the original.

Patient's Printed Name: _________________________________ Relationship to Patient: _________________

Patient Guardian/Patient Signature: __________________________________ Date: ____________________