

**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**

**May we send your billing statement by email? YES/NO**

**Parent/ Guardian (If Patient is Under 18):**

First Name: \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**INSURANCE INFORMATION**

Insurance Subscriber (**Main Policy Holder**): Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

**(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:** \_\_\_\_\_