



100 Tessitore Ct. Suite B | Montrose, CO 81401
970-2787-4710 ♦ Fax 970-615-7007

PATIENT INFORMATION

Patients Last Name		First Name		Middle Initial	
Patients Social Security #			E-mail address		
Mailing Address (Street)		(City,State,Zip)			
Primary Phone	Work Phone	Cell/Other Phone	Sex (Circle One)	Date of Birth	
			Male	Female	
Referring Physician			Primary Care Physician		
Preferred Language		Race		Ethnicity	
<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____		<input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Other _____			

PERSON RESPONSIBLE FOR PAYMENT/TO RECEIVE STATEMENTS (If Different From Patient)

Spouse/Parent Last Name		First Name		Middle Initial		Relationship		Social Security #	
Cell/Other Phone		Address (Street, City, State And Zip)							

SPOUSE/PARENT LIVING WITH (If not already listed)

Spouse/Parent Last Name		First Name		Middle Initial		Relationship		Social Security #	
Date of Birth		Work Phone				Cell/Other Phone			

EMERGENCY CONTACT PERSON (not living with patient)

Name (First and Last)				Home Phone		Relationship	
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INSURANCE INFORMATION

Primary Insurance Co.		ID#		Group or Plan #			
Insured Party (Subscriber)		Subscriber's SS#		Subscriber's DOB		Relationship to patient	
Subscriber's Mailing Address (if different from patient)				(Street)		(City,State,Zip)	
Secondary Insurance Co.		ID#		Group or Plan #			
Insured Party (Subscriber)		Subscriber's SS#		Subscriber's DOB		Relationship to patient	
Subscriber's Mailing Address (if different from patient)				(Street)		(City,State,Zip)	

The information listed above is accurate to the best of my knowledge. I hereby authorize Colorado West General Surgery to disclose all medical records pertaining to me and hereby release Colorado West General Surgery from any liability therefore so long as such records are disclosed in confidence to a hospital, health maintenance organization, managed care organization, health insurance benefit plan, health care entity, professional liability carrier, or peer review body, or the delegated agent of any such entity or body, to verify billing or for the purpose of conducting quality of care review, utilization management review, risk management review, peer review, or other similar activity. I hereby authorize messages regarding appointments with this office to be left on my telephone answering machine or with a family member. I understand that I am ultimately responsible for any of my charges, regardless of insurance coverage. I authorize payment directly to Colorado West General Surgery of any benefits payable to me for services rendered.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have been advised of the Notice of Privacy Practices for Colorado West General Surgery

Signature _____ Date _____
Patient/Parent/Legal Guardian