Front Range Internal Medicine Patient Information Form

Who is your physician: (circle one) Dr. Davis Dr. Kechriotis Dr. Poate Dr. Sato Dr. Spies Dr. Woods

Patient Name (F, MI, L)_____
Prefer to be called:_____ Maiden Name:_____

Address: _____ City: _____ State: _____ Zip:_____

Home: (_____) _____ Cell: (_____) _____ Work: (_____) _____

SSN: _____ D.O.B: _____ Marital Status: Single Married Partner Divorced

Employers Name: _____ Occupation: _____

New to Practice: Who do we thank for you referral to our practice? _____

Please circle Ethnicity: Hispanic/Latino Not Hispanic/Latino Race:_____

HEALTH INSURANCE INFORMATION ---OR--- SELF PAY

(Although we have copied your insurance card, we still need you to complete all the information below)

Primary Insurance: _____ Eff Date: _____ Copay Amount: $_____

Policy Holder Name/ **Self (circle):** _____ Policy Holder SSN: _____
Policy Holder DOB: _____ M/F: _____ Relationship to policy holder: Spouse Child Partner

Policy Subscriber ID#:_____ Policy group#:_____

Secondary Insurance: _____Eff Date: _____

Policy Holder Name/ (circle) Self:_____ Policy Holder SSN:_____
Policy Holder DOB: _____ M/F: _____ Relationship to policy holder: Spouse Child Partner

Policy Subscriber ID#:_____ Group #:_____

EMERGENCY CONTACT INFORMATION

Name: _____ Phone Number:_____ Relationship to Patient:_____

Do you have a living will or durable power of attorney? (Circle one) YES I NO

****If yes please provide a copy for the office****

The undersigned patient or individual acting on behalf of the patient agrees as follows:

1. I authorize HealthOne/Front Range Internal Medicine to render needed treatment to the above named patient.
2. I authorize HealthOne/Front Range Internal Medicine to release any information required for payment of claims.
3. I authorize my insurance benefits to be paid directly to the treating physician, realizing I am responsible to pay non-covered and unauthorized services and I herby authorize the release of pertinent medical information to my insurance carrier.
4. I understand that I am responsible for all charges incurred through HealthOne/Front Range Internal Medicine.
5. **NO SHOW POLICY- I recognize that if I do not cancel/reschedule any future appointments without a 24 hour notice I may be charged a $40 fee.**
6. **PAYMENT IS DUE AT TIME OF VISIT.**

Email Address: _____ (circle) NO EMAIL

Patient/Responsible Party Signature: _____ Date: _____