PATIENT NAME:	
NICKNAME:	DATE OF BIRTH:
GENDER: MALE FEMALE	SOCIAL SECURITY NUMBER:
MAILING ADDRESS:	MARITAL STATUS: M S D W
E-MAIL:	
HOME PHONE NUMBER:	CELL PHONE NUMBER:
WORK NUMBER:	
EMPLOYER NAME & ADDRESS:	
OCCUPATION:	
PRIMARY CARE PHYSICIAN:	
REFERRING PHYSICIAN:	

INSURANCE:	
NAME OF POLICY HOLDER:	POLICY HOLDER DOB:
ID #:	GROUP #:
RELATIONSHIP TO PATIENT:	PHONE # OF POLICY HOLDER:
SOCIAL SECURITY # OF POLICY HOLDER:	

PARENT/GUARDIAN/EMERGENCY CONTACT
NAME:
DATE OF BIRTH:
RELATIONSHIP TO PATIENT:
CONTACT NUMBER:
ADDRESS:

GOVERNMENT REQUIREMENT (PLEASE CIRCLE)	**HOW DID YOU HEAR ABOUT US? (PLEASE CIRCLE)**
AFRICAN AMERICAN	FRIEND
ALASKAN NATIVE	INSURANCE
AMERICAN INDIAN	VALPAK
ASIAN	NEWSPAPER
CAUCASIAN	DOCTOR
LATINO	INTERNET
	OTHER

ASSIGNMENT OF BENEFITS: I authorize Medicare and/or any other insurance plans under which I am covered to make payment to Allergy and Asthma Center of the Rockies or its Assignee of authorized benefits on my behalf, for products or series furnished to me. I understand that by signing this agreement, I accept financial responsibility for the deductible, co-insurance, copayments and all non-covered charges.

RELEASE OF INFORMATION: I authorize the release of any medial or other information necessary to verify benefits, process claims, or provider appropriate care of services provided by Allergy and Asthma Center of the Rockies or its agents. I acknowledge the receipt of the Privacy Practices for Allergy and Asthma Center of the Rockies.

_____ _____

Print Name Date

_____ _____

Signature Date of Birth