

ALPINE ENT

1120 East Elizabeth Street ~ Fort Collins, CO ~ (970)221-1177

PATIENT INFORMATION

Name: _____

Address: _____

City,State,Zip: _____

Phone: (_____) []Home []Work []Other

Phone: (_____) []Home []Work []Other

Patient ID #: _____ Sex: []M []F

Date of Birth: _____

Social Security #: _____

Marital Status: []Married []Single []Divorced

Referring Physician: Self _____

Primary Physician: _____

PATIENT EMPLOYMENT []Employed []Retired []Unemployed

Employer: _____

Phone: _____

Address: _____

City,State,Zip: _____

CONTACTS Name, Phone & Relationship ie. Family, Pharmacy etc

GUARANTOR []Same as Patient

Name: _____

Address: _____

City,StateZip: _____

EMPLOYMENT

Employer: _____

Phone: _____

Social Security #: _____

Date of Birth: _____

PRIMARY INSURANCE []Same as Patient []Same as Guarantor []Other

Insured Party: _____

Insured Phone: _____

Date of Birth: _____

Relationship to Patient: _____

Company: _____

Social Security #: _____

Insured ID: _____

Policy Group: _____

SECONDARY INSURANCE []Same as Patient []Same as Guarantor []Other

Insured Party: _____

Insured Phone: _____

Date of Birth: _____

Relationship to Patient: _____

Company: _____

Social Security #: _____

Insured ID: _____

Policy Group: _____

Patient Signature: _____ Date: _____

Parent or Legal Guardian if Minor

Okay to leave messages at provided phone numbers? _____

It is the policy of this office to bill any balance that is deemed patient responsibility to the parent/guardian who authorized treatment.