



A Higher Level Of Quality Care

BOULDER 1155 Alpine Avenue, Ste 180 Boulder, CO 80304 - P (303) 444-9000 F (303) 444-9073
BROOMFIELD 16677 Lowell Boulevard Broomfield, CO 80023 - P (303) 938-3484 F (303) 665-1443
LAFAYETTE 300 Exempla Circle, Ste 250 Lafayette, CO 80026 - P (303) 776-9400 F (303) 682-2952
LONGMONT 2030 Mountain View, Ste 420 Longmont, CO 80501 - P (303) 776-9400 F (303) 682-2952
LOUISVILLE 90 Health Park Drive, Ste 340 Louisville, CO 80027 - P (303) 666-4343 F (303) 666-6741

PATIENT INFORMATION SHEET

Today's date _____

Patient's name _____ Sex: M F Date of birth _____

Address _____

STREET ADDRESS CITY STATE ZIP

Social Security # _____ Home phone (____) _____ Cell (____) _____

(As Needed for Insurance Billing)

Currently employed? Yes No Employer _____ Work# _____

Fulltime student? Yes No Patient's marital status: Single Married Separated Divorced Widowed

If patient is under the age of 18, please tell us who we should talk to regarding any medical questions:

Name _____ Relationship _____ Phone _____

Patient's primary care physician: _____ Physician's phone _____

Name of the nearest relative not living with you, or a close friend we can contact in case of emergency

Name _____ Relationship _____

City/State _____ Home # _____ Work # _____

INSURANCE INFORMATION

If the patient is not the policy holder for medical insurance, please complete this section

Policy holder's name _____ ID # _____

(As Appears on Insurance Card)

Address _____ Date of birth _____

STREET ADDRESS CITY STATE ZIP

Employer _____ Work # _____

PHARMACY

Preferred Pharmacy _____

Address _____

STREET ADDRESS CITY ZIP

Phone _____



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INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Alpine Urology, P.C. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance and all collection costs should this account be assigned for collection.

I accept and understand the responsibility of notifying Alpine Urology, P.C. of any requirement by my insurance company of pre-authorization prior to any hospital admission or surgical procedure, whether done in office or in hospital. I understand that it is also my responsibility to verify that a pre-authorization has been completed prior to any hospital admission or surgical procedure.

I also understand if I fail to get a referral, if necessary, I will be responsible for the charges.

DATE _____ SIGNATURE _____