

**PLEASE PRINT**

<b>For Official Use Only</b>		
Patient # _____	Location _____	Photo ID Verified <input type="checkbox"/>
Date of First Appointment _____		

**PATIENT INFORMATION**

Patient's Name: \_\_\_\_\_ Home Phone # \_\_\_\_\_  
 Address: \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
Street City State Zip  
 E-Mail Address: \_\_\_\_\_ Best number for messages: Home  Cell   
 Date of Birth: \_\_\_\_\_ SEX: Male  Female  Relationship Status: \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Have you or any other family members received medical care by our practice? If so, Who: \_\_\_\_\_ When: \_\_\_\_\_

**EMERGENCY CONTACT:**

Relationship: \_\_\_\_\_ Contact Phone # \_\_\_\_\_

**PHYSICIAN INFORMATION**

Primary Care Physician: \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
 Address: \_\_\_\_\_ Fax # ( ) \_\_\_\_\_  
Street City State Zip  
 Specialist/Other: \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
 Address: \_\_\_\_\_ Fax # ( ) \_\_\_\_\_  
Street City State Zip

Written report(s) will be sent to above Physicians unless otherwise noted; I give permission, PCP: Yes  No  Specialist/Other: Yes  No

**How did you first hear about Colorado Allergy and Asthma Centers? (Check One)**

Primary Care: as above  Internet Search  Google®  Friend \_\_\_\_\_  
 Specialist: as above  Advertisement  CAAC Patient \_\_\_\_\_  Other \_\_\_\_\_  
 Insurance Company  Radio  Family Member \_\_\_\_\_

**EMPLOYMENT INFORMATION**

**Patient OR parent/guardian of a minor**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ SSN # \_\_\_\_\_  
 E-mail Address: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Phone # \_\_\_\_\_  
 Employer Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Spouse/Significant other OR the second parent/guardian of a minor**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ SSN # \_\_\_\_\_  
 E-mail Address: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Phone # \_\_\_\_\_  
 Employer Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**INSURANCE INFORMATION (Primary)**

Ins Company: \_\_\_\_\_ Phone # \_\_\_\_\_  
 Policy Holder/Subscriber: \_\_\_\_\_  
 Subscriber Address: \_\_\_\_\_  
 Subscriber Date of Birth: \_\_\_\_\_ SSN # \_\_\_\_\_  
 Subscriber Relationship: \_\_\_\_\_  
 Ins Address: \_\_\_\_\_  
 Member/ID # \_\_\_\_\_ Group: \_\_\_\_\_

**INSURANCE INFORMATION (Secondary)**

Ins Company: \_\_\_\_\_ Phone # \_\_\_\_\_  
 Policy Holder/Subscriber: \_\_\_\_\_  
 Subscriber Address: \_\_\_\_\_  
 Subscriber Date of Birth: \_\_\_\_\_ SSN # \_\_\_\_\_  
 Subscriber Relationship: \_\_\_\_\_  
 Ins Address: \_\_\_\_\_  
 Member/ID # \_\_\_\_\_ Group: \_\_\_\_\_

**FOR OFFICE USE ONLY**

I authorize the release of any information necessary to process claims. I request payment of benefits to Colorado Allergy and Asthma Centers. I understand I am financially responsible for charges not covered by this authorization.

I understand and agree if care at Colorado Allergy and Asthma Centers requires Primary Care Physician referral, it is my responsibility to see that the referral is current prior to receiving care at Colorado Allergy and Asthma Centers. If no referral is present in advance, I agree to pay for charges at the time of service.

Patient/Guardian Signature \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Witness \_\_\_\_\_ Date \_\_\_\_\_

**Consent for care of minors**

Because my son/daughter is a minor (less than eighteen (18) years of age) and primarily supported by parent or guardian, I understand and agree that he/she may be evaluated and/or treated by Colorado Allergy and Asthma Centers' staff if I am not present to give consent. This may include, but necessarily limited to, physical exams, skin tests, laboratory test, allergy injections and the prescription of medications in my absence. This agreement will be in effect until revoked by me in writing.

Signature \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Witness \_\_\_\_\_ Date \_\_\_\_\_