For Official Use Only

Patient #_____ Location_____ Photo ID Verified ❑

Date of First Appointment_____

PLEASE PRINT

PATIENT INFORMATION

Patient's Name: _____ Home Phone # _____

Address: _____ Cell Phone # _____

Street City State Zip

Best number for messages:

E-Mail Address: _____ 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_____