5446 N. Academy Blvd. Suite 102
Colorado Springs, CO 80918
Office: 719-594-0071 Fax: 719-260-1964

YEAR 2018

New Patient Application

Please allow our staff to photocopy your driver's license and insurance card. All information you provide us is confidential. We comply with all Federal privacy standards. Please print your information clearly.

________________________ **Today's Date (MM/DD/YYYY)**

How Did You Hear About Us?
○ Web ○ Event ○ Friend/Family

______________________________ **Name of Referral**

____ **Patient's Last Name**

______________________________ **Social Security Number**

_________________ **Birthdate**

____________ **Age**

____ **Patient's First Name**

______________________________ **Patient's Middle Name**

Gender:
○ Male ○ Female

____ **Address**

Marital Status:
○ Married ○ Single
○ Divorced ○ Separated ○ Widowed

____________________________ **City**

______________ **State/Province**

____________________ **Zip/Postal Code**

____________________________ **Home Phone**

______________________________________ **Cell Phone**

______________________________ **Spouse's Name**

____ **Email address**

______________________________ **Child's Name and Birthdate**

____________________________ **Emergency Contact Name**

______________________________________ **Emergency Contact Phone Number**

______________________________ **Child's Name and Birthdate**

____________________________ **Occupation**

______________________________________ **Employer Name**

______________________________ **Child's Name and Birthdate**

____ **Employer Address**

May we contact you at work?
○ Yes ○ No

____________________________ **City**

_____________ **State/Province**

____________________ **Zip/Postal Code**

Preferred Method of Contact
○ Home ○ Cell ○ Work ○ Email ○ None

____________________________ **Primary Care Physician's Name**

______________________________________ **Primary Care Physician's Phone Number**

______________________________ **Primary Care Physician's Address**

Insurance Information

_____________________________ **Insurance Carrier Name**

______________________________________ **Policy Number**

______________________________ **Group ID Number**

______________________________ **Policy Holder's Last Name**

______________________________________ **Policy Holder's First Name**

______________________________ **Policy Holder's Middle Name**

______________________________ **Policy Holder's Birthdate**

Who Carries this Policy? ○ **Self** ○ **Spouse** ○ **Parent**