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DEMOGRAPHIC INFORMATION

Patient Name: _____ Date of Birth: _____

Person Responsible for Payment (If not patient): _____

Relationship: _____ Date of Birth: _____ SSN: _____

Address: _____ City: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

What is the best way to contact you? Home _____ Cell _____ Work _____

Email Address: _____ May we send test results to you by email? _____

Race & Ethnicity (Census Bureau Categorization Purposes): American Indian or Alaskan Native: _____ Asian: _____
African American: _____ Black Hispanic or Latino: _____ Caucasian: _____ White Hispanic or Latino: _____
Native Hawaiian and other Pacific Islander: _____ Refused: _____ Language Preference: _____

Marital Status: _____ Spouse/Significant Other: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

INSURANCE INFORMATION

Insurance Subscriber: Patient: _____ Responsible Party: _____ Other: _____ Name: _____

Subscriber's Date of Birth: _____ Patient's Relationship to Insurance Subscriber: _____

Insurance Company: _____ Company Phone: _____

Member/Subscriber Number: _____ Group/Policy Number: _____

****Assignment of Insurance Benefits****

I hereby authorize Longs Peak Family Practice to recover from my insurance company, payment for any health service that is provided to me. I understand that I am financially RESPONSIBLE for ALL co-pays, co-insurance, deductibles, and non covered charges that is determined by my insurance company. I hereby authorize Longs Peak Family Practice to release all information necessary to secure such payments. A photocopy or electronic scan of this statement is to be considered as valid as the original.

Responsible Party/Patient Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____