

Welcome To Our Office

PLEASE PRINT and COMPLETE ALL PARTS

FRONT RANGE THERAPIES PARKER, P.C.

Patient Number _____

Today's Date _____

PATIENT NAME: (This section refers to PATIENT ONLY)

Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Employer _____

Date of Birth _____ Age _____ Sex _____ Social Security # _____ Occupation _____

Spouse _____ Employer _____ Work Phone _____

Relationship to Responsible Party Self Spouse Son Daughter Other

RESPONSIBLE PARTY: (Person who should receive the bill)

Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Social Security # _____

Date of Birth _____ Age _____ Employer _____

HOW DID YOU HEAR ABOUT US?: _____

REFERRING PHYSICIAN NAME (PCP): _____ PHONE: _____

INSURANCE: (Please complete thoroughly. We will need a copy of your insurance card.)

Primary Insurance _____ Secondary Insurance _____

Address _____ Address _____

City, State, Zip _____ City, State, Zip _____

Phone: Area () _____ Phone: Area () _____

Primary Insured Person _____ Primary Insured Person _____

ID/Policy # _____ Suffix _____ ID/Policy # _____ Suffix _____

Group # _____ Group # _____

Employer _____ Employer _____

Co-Payment \$ _____ Co-Payment \$ _____

Auto Injury Claim # _____ Date of Accident/Surgery _____

Work Comp Claim # _____ Date of Accident/Surgery _____

Other Injury (Specify) _____ Date of Accident/Surgery _____

NOTIFY IN EMERGENCY: (NOT LIVING WITH YOU)

Name _____ Relationship _____ Phone _____

CONSENT FOR TEST RESULTS I give Front Range Therapies Parker, P.C. permission to leave all X-ray, lab results, test results, and other medical information and advice on: (check all that apply)
 Voice mail at work Answering machine at home Other _____ Do not leave message

I hereby acknowledge that I have received a copy of Front Range Therapies Parker, P.C. Notice of Privacy Practices. I authorize the release of any medical information and payment of medical benefits to the undersigned physician or supplier for services necessary to process a claim. I agree to be responsible for any deductible, co-insurance, co-pay, or any other balance not paid by my insurance.

Patient name: _____ Date: _____

Signature: _____ Relationship to patient: self parent guardian (check one)