2643 Patterson, Suite 506 * St. Mary's Physician's Tower * Grand Junction, Colorado 81506 * 970-242-8177 * fax: 970-255-3558

PATIENT INFORMATION

Patients Last Name	First Name	Middle Initial
Patients Social Security #	Email	
Mailing Address (Street)	(City,State,Zip)	

Home Phone	Work Phone	Cell/Other Phone	Sex (Circle One) Male Female	Date of Birth

Referring Physician	Primary Care Physician

Preferred Language ☐ English ☐ Spanish ☐ Other ______________	**Race** ☐ Black or African American ☐ Hispanic ☐ White ☐ Other ____________	**Ethnicity**

SPOUSE/PARENT/PERSON RESPONSIBLE FOR PAYMENT

Spouse/Parent Last Name First Name Middle Initial	Relationship	Social Security #
	Address, If Different From Patient (Street, City, State And Zip)	
Home Phone	Cell/Other Phone	Work Phone

EMERGENCY CONTACT PERSON (not living with patient)

Name (First and Last)	Home Phone	Relationship

INSURANCE INFORMATION

Primary Insurance Co.			
ID#		Group or Plan #	
Insured Party (Subscriber)	**Subscriber's SS#**	**Subscriber's DOB**	**Relationship to patient**
Secondary Insurance Co.			Phone
ID#		Group or Plan #	
Insured Party (Subscriber)	**Subscriber's SS#**	**Subscriber's DOB**	**Relationship to patient**

The information listed above is accurate to the best of my knowledge. I hereby authorize Colorado West Otolaryngologists to disclose all medical records pertaining to me and hereby release Colorado West Otolaryngologists from any liability therefore so long as such records are disclosed in confidence to a hospital, health maintenance organization, managed care organization, health insurance benefit plan, health care entity, professional liability carrier, or peer review body, or the delegated agent of any such entity or body, to verify billing or for the purpose of conducting quality of care review, utilization management review, risk management review, peer review, or other similar activity. I hereby authorize messages regarding appointments with this office to be left on my telephone answering machine or with a family member. I understand that I am ultimately responsible for any of my charges, regardless of insurance coverage. I authorize payment directly to Colorado West Otolaryngologists, P.C. of any benefits payable to me for services rendered.

Signature____ **Date** ______________________
Patient/Parent/Legal Guardian

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have been advised of the Notice of Privacy Practices for Colorado West Otolaryngologists, P.C.

Signature____ **Date** ______________________
Patient/Parent/Legal Guardian