Rose Medical Center campus • Physician Office Building II
4500 E. 9th Avenue • Suite 720S • Denver, CO 80220
303-355-3525 • 303-355-0255 FAX • www.denverdigestive.com

WELCOME TO OUR OFFICE!

Please complete this form upon your first visit so your claim can be processed efficiently. Notify us at future visits if any of the information changes.

Patient Information

Patient's LEGAL name ______________________________
First Name MI Last

Mailing Address ______________________________ ❑ Male ❑ Female
Street Apt/Unit # City State Zip

Home Phone (________) ____________________ Can we leave a message at this # ❑ Yes ❑ No

Work Phone (________) ____________________ Can we leave a message at this # ❑ Yes ❑ No

Cell Phone (________) ____________________ Can we leave a message at this # ❑ Yes ❑ No

E-Mail Address ______________________________

Marital Status ______________ Date of Birth ______________ Age _____ SS# ______________

Employer ______________________________

Emergency Contact Information

Name ______________________ Address ______________________

Relationship to patient ______________________ Home Phone (________) ______________

Employer ______________________ Work Phone (________) ______________

Insurance

Policy Holder ______________________ Policy Holder's Date of Birth ______________

Insurance Co. Name ______________________ Insurance Group Name ______________

Insurance Co. Address ______________________________

Policy # ______________ Group #______________ Policy Holder's SS# ______________

If insurance is under spouse please list their social security # and date of birth for billing SS#______________ DOB__________

Physician Information

Primary Care Physician ______________________ Referring Physician ______________________

Address ______________________ Address ______________________

Phone (_____) ______________________ Phone (_____) ______________________

Fax (_____) ______________________ Fax (_____) ______________________

PLEASE SIGN BY THE X

I hereby assign, transfer and set over to Denver Digestive Health Specialists, P.C. all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of medical information needed to determine my benefits. This authorization shall remain valid, until written notice is given by me revoking this authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

I authorize the release of any medical information from other healthcare providers and/or healthcare facilities to Denver Digestive Health Specialists, P.C. that is needed during the course of my care. This authorization shall remain valid until written notice is given by me to the office revoking this authorization.

X: ______________________________ ______________
Patient Signature Date