

Registration Information
(page one)

For office use only:
 TCW DMT HCC DWB _____ FC LV CH GR GO

 Date Language: _____
 Yes, interpreter required
 FRC provides Patient provides

Full legal name (please print in ink throughout this form) _____

Maiden or other name _____ Email address _____

Address: Street (if P.O. Box, please include street address) _____ City _____ State _____ Zip _____
 () () ()

Telephone—If none, please list one of friend or relative _____ Cellular phone number _____ Work phone (list work hours) _____
 M F

Birth date _____ Age _____ Sex (circle one) _____

Social Security number _____ Spouse's Social Security number _____

Single Married Widowed Divorced
 (Please circle current status)

Emergency contact: _____
 Name Relationship
 () ()
 Phone days Phone evenings

EMPLOYMENT INFORMATION

Employer's name: _____

Your present occupation: _____

Work phone: () _____

Name of spouse: _____

Spouse's employer: _____

Spouse's work phone number: () _____

Referring physician: _____
 (Please be specific) First name Last name
 Address: _____ ()
 Phone number

Primary physician: _____
 First name Last name
 Address: _____ ()
 Phone number

I learned about your practice from (please check all that apply):

my own doctor or my referring doctor a family member, friend, or acquaintance
 the Yellow Pages or similar directory my insurance company/insurance adjustor
 the Front Range Center for Brain & Spine Surgery web site
 an ad by Front Range Center for Brain & Spine Surgery
 the reputation of Front Range Center for Brain & Spine Surgery
 an email from Front Range Center for Brain & Spine Surgery
 other _____

Continued on other side

Registration Information (page two)

Name (please type or print)

Insurance Information**PRIMARY CARRIER**

Company name: _____ Group no. _____
 Co.'s address: _____ Co.'s phone: () _____
 Subscriber's name: _____ Date of birth _____ Relationship: _____
 Policy number: _____ Written referral required? Yes No

SECONDARY CARRIER

Company name: _____ Group no. _____
 Co.'s address: _____ Co.'s phone: () _____
 Subscriber's name: _____ Date of birth _____ Relationship: _____
 Policy number: _____ Written referral required? Yes No

AUTOMOBILE ACCIDENT INFORMATION

Describe the accident: _____
 Claim number: _____ Date of injury: _____
 Insurance company: _____ Co.'s phone: () _____
 Insurance company address: _____
Is this your auto insurance, or a third party's insurance? _____
 Adjustor: _____ Mine Name of third-party insurer _____

WORKER'S COMPENSATION INFORMATION

For office use only: Gatekeeper _____

Your employer when injured: _____
 Claim number: _____ Date of injury: _____
 Insurance company: _____ Co.'s phone: () _____
 Insurance company address: _____
 Adjustor: _____

LEGAL INFORMATION

Are you contacting an attorney(s) to help you in litigating a personal injury, auto accident, or Worker's Compensation suit? If yes, please give attorney's or attorneys' name(s), phone number, and address.

 Name () Phone number

 Address

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits associated with this office, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to the Front Range Center for Brain & Spine Surgery, P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. **I hereby agree to pay any and all charges that exceed or that are not covered by insurance.** I hereby authorize said assignee to release all information to secure the payment. To ensure continuity of care, I hereby authorize the release of all medical records to my primary and referring physicians. I hereby release copies of this information sheet to any hospital I may be admitted to. I also authorize Medicare, private insurance, and any other health plan to furnish said assignee any information regarding payment of my claim.

 Signature Date