COLORADO WEST OTOLARYNGOLOGISTS, P.C.

425 Patterson, Suite 503 • Grand Junction, CO 81506
(970) 245-2400 • Fax (970) 242-9092

PATIENT INFORMATION **Please Print in Black Ink**

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

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

Marital Status (Circle One) Single Married Widowed Divorced	Referring Physician	Name Of Your Primary Care Physician

How were you referred to us? (Circle one) Physician Family Friend Yellow pages Other ______________________

PERSON RESPONSIBLE FOR PAYMENT (If different from Patient)

Responsible Party's Last Name	First Name	Middle Initial	Home Phone
Address, If Different From Patient (Street, City, State And Zip)			Work Phone
Sex (Circle One) Male Female	Date of Birth	Social Security #	Relationship to patient

SPOUSE/PARENT INFORMATION (Adult living with you)

Spouse/Parent Last Name	First Name	Middle Initial	Home Phone
Address, If Different From Patient (Street, City, State And Zip)			Work Phone
Sex (Circle One) Male Female	Date of Birth	Social Security #	Relationship to patient

EMERGENCY CONTACT PERSON (not living with patient)

Name (First and Last)	Home Phone	Relationship to patient

HAVE WE SEEN ANY OF YOUR FAMILY MEMBERS? (List additional names on back please.)

Name	Relationship	Name	Relationship

INSURANCE INFORMATION (Please complete even if card is provided)

Primary Insurance Co.			Phone
Address (not needed if card was provided)	City	State	Zip
ID#	Group or Plan #		

Insured Party (Subscriber)	Insured Party's DOB	Insured Party's Employer	Relationship to patient

Secondary Insurance Co.			Phone
Address (not needed if card was provided)	City	State	Zip
ID#	Group or Plan #		

Insured Party (Subscriber)	Insured Party's Employer	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