Spruce Street Internal Medicine
2575 Spruce Street, Boulder, CO 80302

PATIENT INFORMATION:

Name _____ M____ F_____
(Last) (First legal) (Middle)

Date of Birth _____ SS # _____ Marital Status: M S W D

Mailing Address _____
(street) (city) (state) (zip)

Hm Phone _____Cell _____ Ph_____

Patient Employer _____Wk Ph _____

Referred by _____ Phone_____

Emergency Contact _____Phone _____

Spouses/or other name _____ SS#_____

Responsible Party _____ SS#_____

Employer of responsible person _____Phone _____

Leave message on answering machine: home_____ work _____ both_____

INSURANCE INFO: **This *must* be completed. Please present current insurance card.**

Insured's Name: _____ DOB _____
(Last) (First legal) (Mi)

Primary Insurance _____Through Employer? _____

ID#_____ Group#_____Co-Pay_____

Secondary Insurance _____

ID#_____ Group#_____

ALL PATIENTS PLEASE COMPLETE AND SIGN THIS RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS:

"I hereby authorize Spruce Street Internal Medicine to release to, or request from my insurance company, other physicians or hospitals, any information including the diagnosis and records of any treatment or examination rendered to me during my care, and that this information may be faxed. I also authorize and request my insurance companies to pay directly to the above-named corporation the amount due me in my pending claim for medical treatment or service. I also understand that if it becomes necessary to refer my account for collection, I will be liable for the reasonable collection fees and court costs expended therein. "Duplicate of this release & assignment is as valid as the original"

Patient's Signature _____Date_____
(or Parent/Guardian if patient is a minor)