Painted Rock Family Medicine

Balanced Healthcare for a Balanced Life

Please review and update the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION -- PLEASE PRINT

Last Name: _____

First Name: _____

Middle Name: _____

Address: _____

City: _____ State:_____

Zip: _____

Home Phone: _____

Work Phone: _____

Mobile Phone: _____

Sex: ___ **F** ____**M**

Date of Birth: _____

Social Security No.:_____

Patient email: **{**_____

Required by government mandate [although you may refuse]:

Language: _____

Race: _____

Ethnicity: _____

Marital Status: _____

Guarantor Information (to whom statements are sent)

Name: _____

Address: _____

_____

_____

Relationship to patient: _____

Date of Birth: _____

Social Security No.: _____

Phone: ( ) _____ - _____

Emergency Contact Information

Name: _____

Relationship: _____

Phone: _____

Mobile Phone:( ) _____ - _____

Employer information

Employer: _____

Address: **{**_____

_____

_____

_____

Phone: _____

Other

Patient Referred by:

Primary Care Provider:

Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email

Pharmacy Information:

Name:

Crossroads:

Phone:

9998 Dransfeldt Road
Parker, CO 80134

PaintedRockFamilyMedicine@gmail.com
PainedRockFamilyMedicine.com

T (303) 214-0333
F (303) 214-0332

Primary Insurance Information
Insurance Plan Name: _____
Name: _____ Policy Holder Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____ Sex (please circle): **M** or **F**
Employer Name: _____
Patient's relationship to policy holder:

Secondary Insurance Information
Insurance Plan Name: _____

Name: _____ Policy Holder Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____ Sex (please circle): **M** or **F**
Employer Name: _____
Patient's relationship to policy holder:

To the best of my knowledge the above information is complete and accurate.

Signed_____ **Date:**_____

Please sign and date each item below

ACKNOWLEDGEMENT AND AUTHORIZATION:

- **I have read and understand the HIPAA/Privacy Policy for Painted Rock Family Medicine**

Signed_____ **Date:**_____

- **I hereby assign my insurance benefits to be paid directly to the healthcare provider**

Signed_____ **Date:**_____

- **I authorize {{MEDICALGROUPBILLINGNAME}} to release medical information required to process my claim**

Signed_____ **Date:**_____

- **I have read and understand the Financial Policy for {{MEDICALGROUPBILLINGNAME}}**

Signed_____ **Date:**_____

- **I authorize {{MEDICALGROUPBILLINGNAME}} to obtain/have access to my medication history**

Signed_____ **Date:**_____

- **I authorize my provider's office to contact me by mobile phone**

Signed_____ **Date:**_____

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