Colorado West Otolaryngologists, PC

2643 Patterson Rd, Suite 503 ◆Grand Junction, CO 81506
970-245-2400 ◆ Fax 970-242-9092

PATIENT INFORMATION

Patients Last Name	First Name	Middle Initial		
Patients Social Security #	E-mail address			
Mailing Address (Street)	(City,State,Zip)			
Primary Phone	Work Phone	Cell/Other Phone	Sex (Circle One) Male Female	Date of Birth
Referring Physician	Primary Care Physician			
Preferred Language ☐ English ☐ Spanish ☐ Other _____	**Race** ☐ Black or African American ☐ Hispanic ☐ White ☐ Other _____	**Ethnicity**		

PERSON RESPONSIBLE FOR PAYMENT/TO RECEIVE STATEMENTS (If Different From Patient)

Spouse/Parent Last Name	First Name	Middle Initial	Relationship	Social Security #
Cell/Other Phone	Address (Street, City, State And Zip)			

SPOUSE/PARENT LIVING WITH (If not already listed)

Spouse/Parent Last Name	First Name	Middle Initial	Relationship	Social Security #
Date of Birth	Work Phone		Cell/Other Phone	

EMERGENCY CONTACT PERSON (not living with patient)

Name (First and Last)	Home Phone	Relationship

INSURANCE INFORMATION (must be listed if you want us to bill your insurance)

Primary Insurance Co.	ID#	Group or Plan #	
Insured Party (Subscriber)	**Subscriber's SS#**	**Subscriber's DOB**	**Relationship to patient**
Subscriber's Mailing Address (if different from patient) (Street)		(City,State,Zip)	
Secondary Insurance Co.	ID#	Group or Plan #	
Insured Party (Subscriber)	**Subscriber's SS#**	**Subscriber's DOB**	**Relationship to patient**
Subscriber's Mailing Address (if different from patient) (Street)		(City,State,Zip)	

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.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have been advised of the Notice of Privacy Practices for Colorado West Otolaryngologists, P.C.

Signature_____ **Date** _____
Patient/Parent/Legal Guardian