

INTEGRITY FAMILY HEALTHCARE, P.C.

1465 KELLY JOHNSON BLVD., SUITE 100
COLORADO SPRINGS, CO 80920

TELEPHONE: (719)572-0951

FAX: (719)572-0955

PATIENT REGISTRATION

PATIENT INFORMATION

Last Name _____ First Name & Initial _____

Sex: M F Date of Birth _____ Driver's License # _____

Street Address _____

City, State, Zip _____

Social Security # _____ Home Phone # _____

Employer _____

Work Phone _____

Spouse's Name _____ Spouse's Work Phone _____

Emergency Contact _____ Phone # _____

RESPONSIBLE PARTY Same as patient

Last Name _____ First Name & Initial _____

Street Address _____

City, State, Zip _____

Sex: M F Employed? Y N Employer _____

Home Phone # _____ Work Phone # _____ ext _____ Marital Staus _____

Date of Birth _____ Social Security # _____ Driver's Lic # _____

Referring Physician/Source _____

INSURANCE INFORMATION NOTE: Insurance information **MUST** be filled out completely!

Guarantor _____ DOB _____

Insurance #1 _____

Group Name or Number _____ Effective Date _____ Policy/Member ID # _____

Insurance #2 _____

Group Name or Number _____ Effective Date _____ Policy/Member ID # _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize and request payment directly to Integrity Family Healthcare, P.C., of any Medical, Major Medical, and/or Surgical benefits due to me under the terms of my insurance policy for services rendered. I agree to and accept responsibility to pay for any non-covered services.

SIGNATURE (Insured)

DATE

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Integrity Family Healthcare, P.C., to release any information acquired during the course of my treatment necessary to process insurance claims.

SIGNATURE (Insured)

DATE

24 HOUR CANCELLATION NOTICE REQUIRED TO AVOID A FEE Patient Initial: _____