Acupuncture Physicians of Colorado

9101 Harlan St., #350 Westminster, CO 80031 Phone: 720-381-6100 Fax: 720-381-6133

PATIENT INFORMATION

Name: ____ Date of Birth: __________________SSN: _______________________

Mailing Address: _______________________________________ City, State & Zip: ____

Primary Phone #: ______________________________________ Secondary Phone #: ____

Employer: ____ Employer Phone #: ____

Primary Care Physician: _________________________________ Phone #: ____

Name of spouse/partner: _________________________________ Phone #: ____

Name of referring physician/friend/ family member: ___________________________________ Phone # _________________________

INSURANCE INFORMATION

Is your injury/illness the result of a **workers' compensation** injury? _________YES _________ NO
Is your injury/illness the result of an **auto accident**? _________YES _________ NO

IF YES:

Workers' Compensation OR Personal Auto Insurance Company: ____
Claim #: ____ Date of Injury: __________________________________
Adjuster: ____ Phone #: _______________________________________
Claims Address: ____

Please provide health insurance information in addition to workers' compensation/auto.

PRIMARY HEALTH INSURANCE COMPANY NAME: ________________________ ID#: _______________________ Group #: __________
Insurance Phone #: ____________________ Claims Address: ____

Policy Holder (if different than self):____ Relationship to Patient: _______________________
Date of Birth: ____ SSN: ____
Address: ____ City, State & Zip: ______________________________________
Employer: ____ Home/Cell #: ____

SECONDARY HEALTH INSURANCE COMPANY NAME: _______________________ ID#: ______________________ Group #: __________
Insurance Phone #: ____________________ Claims Address: ____

Policy Holder (if different than self): ____Relationship to Patient: _______________________
Date of Birth: ____ SSN: ____
Address: ____City, State & Zip: ______________________________________
Employer: ____ Home/ Cell #: ____

EMERGENCY CONTACT

Name: ____ Relationship: ______________________Phone: __________________________

MEDICAL DISCLOSURE

I give Acupuncture Physicians of Colorado permission to leave messages at phone #:____
I give Acupuncture Physicians of Colorado permission to discuss my medical care with: ____
Relationship: ____ Phone: ____

____ ____

Signature (Patient/Responsible Party) Date