

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: XXX-XX- _____

Mailing Address: _____ City, State & Zip: _____

Primary Phone #: _____ Secondary Phone #: _____

Employer: _____ Employer Phone #: _____

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 insurance.

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 #:** _____

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: _____

Personal relationship (spouse, partner, parent, friend, etc.): _____ **Phone:** _____

Signature (Patient/Responsible Party)

Date