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DENVER, COLORADO 80218-1217

Phone: 303-321-1333  
Toll Free: 888-900-1333  
FAX: 303-321-0620

# Patient Information Form

*Please complete all information*

IF YOU THINK YOU MAY HAVE SEEN ONE OF OUR DOCTORS BEFORE OR WISH TO GIVE YOUR INFORMATION OVER THE PHONE PRIOR TO YOUR APPOINTMENT DATE CALL **321-1333**.

DID ANOTHER PHYSICIAN REFER YOU TO OUR OFFICE?  <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, REFERRING PHYSICIAN'S NAME, ADDRESS & PHONE	IF NOT PHYSICIAN REFERRED WHO MAY WE THANK FOR REFERRING YOU?
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PATIENT'S FULL NAME (LAST, FIRST, M.I.)	PATIENT'S S.S.#	SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTHDATE	AGE
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PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP)	PATIENT'S HOME PHONE	MARITAL STATUS: <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED
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NEXT OF KIN/SPOUSE (NAME, ADDRESS, PHONE)	MOTHER'S MAIDEN NAME (PRESCRIPTION REFILL SECURITY CODE)
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RESPONSIBLE PARTY	RESPONSIBLE PARTY'S RELATION TO PATIENT	RESPONSIBLE PARTY'S ADDRESS AND PHONE
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PATIENT'S EMPLOYER	PATIENT'S EMPLOYER'S ADDRESS (STREET, CITY, STATE, ZIP) AND PHONE	OCCUPATION
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PARENT/SPOUSE EMPLOYER (COMPANY NAME, ADDRESS, PHONE)	OCCUPATION
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INJURY OR COMPLAINT	DATE OF INJURY AND CAUSE	PREVIOUS X-RAYS TAKEN – WHERE AND WHEN
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Disease History: Do you have or have you had any of the following?

**LUNG**

- Bronchitis
- Emphysema
- Asthma
- TB
- Sinusitis
- Respiratory Infections
- Sleep Apnea
- Smoker  
     Packs per Day \_\_\_\_\_  
     # of Years \_\_\_\_\_
- Former Smoker  
     Year Quit \_\_\_\_\_

**VASCULAR**

- High Blood Pressure
- Heart Attack
- Heart Murmur
- Circulatory Problem
- Heart Disease
- Sickle Cell
- Stroke

**SYSTEMIC**

- Muscle/Nerve Disease
- Diabetes
- Glandular Trouble
- Hepatitis:    Type A  
                            Type B  
                            Type C
- Kidney/Bladder Problems
- Alcohol Use   Y / N  
                           Amount \_\_\_\_\_
- Stomach/Bowel Problem
- Polio
- Back/Disc Disease
- Jaundice
- Convulsions
- Headaches
- Fainting
- Glaucoma
- Malignant Hyperthermia (High Fever)
- HIV Virus/AIDS

Comments: \_\_\_\_\_

Drug History: In the last six months have you taken any of the following drugs?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Steroids                         | <input type="checkbox"/> Aspirin              | <input type="checkbox"/> Insulin or diabetic |
| <input type="checkbox"/> Birth Control Pills              | <input type="checkbox"/> Arthritis Medication | <input type="checkbox"/> Thyroid             |
| <input type="checkbox"/> Antibiotics                      | <input type="checkbox"/> Tranquilizers        | <input type="checkbox"/> Blood Pressure      |
| <input type="checkbox"/> Asthma Medication                | <input type="checkbox"/> Narcotics            | <input type="checkbox"/> Heart Medication    |
| <input type="checkbox"/> Anti-Coagulants (blood thinners) | <input type="checkbox"/> Other _____          |  |

Please list your current medications: \_\_\_\_\_

Allergy and Reaction:

- |   |   |
|---|---|
| <input type="checkbox"/> Narcotics: _____   | <input type="checkbox"/> Other Drugs: _____ |
| <input type="checkbox"/> Antibiotics: _____ | <input type="checkbox"/> Latex: _____       |
| <input type="checkbox"/> Anesthetics: _____ | <input type="checkbox"/> Non-Medical: _____ |

Have you had any operations within the last six months?  Yes  No Please list: \_\_\_\_\_

Please list the operations you have had during your life: \_\_\_\_\_

Please list the major illnesses you have had during your life: \_\_\_\_\_

### INSURANCE INFORMATION

DO YOU HAVE MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICARE ID NUMBER:	DO YOU HAVE MEDICAID? <input type="checkbox"/> YES <input type="checkbox"/> NO	STATE ID NUMBER
INSURANCE COMPANY: PPO AFFILIATED? <input type="checkbox"/> YES <input type="checkbox"/> NO	INSURANCE COMPANY'S ADDRESS:	POLICY NUMBER	POLICY OWNER AND OWNER'S RELATIONSHIP TO PATIENT:
IS THE GROUP INSURANCE THROUGH AN EMPLOYER? IF YES, GIVE EMPLOYER'S NAME IF NOT LISTED ABOVE: <input type="checkbox"/> YES <input type="checkbox"/> NO EMPLOYER:		IF EMPLOYER NOT PREVIOUSLY LISTED, PLEASE GIVE EMPLOYER'S NAME, ADDRESS AND PHONE	
IS PATIENT COVERED BY ANOTHER INSURANCE COMPANY? IF YES, GIVE NAME OF COMPANY: <input type="checkbox"/> YES <input type="checkbox"/> NO INSURANCE COMPANY:			POLICY NUMBER:

### ACCIDENT INFORMATION

IS THIS VISIT DUE TO AN INJURY RESULTING FROM ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, HOW DID ACCIDENT OCCUR? (EXPLAIN BRIEFLY)		
WHERE DID ACCIDENT OCCUR?	DATE OF ACCIDENT:	WAS ACCIDENT WORK-RELATED? IF YES, GIVE NAME OF EMPLOYER AT TIME OF ACCIDENT: <input type="checkbox"/> YES <input type="checkbox"/> NO EMPLOYER:	
COMPENSATION CLAIM NUMBER: (IF APPLICABLE)	NAME AND ADDRESS OF COMPENSATION CARRIER:		
IF AUTO ACCIDENT RELATED:	NAME AND ADDRESS OF AUTO INSURANCE CO.: PPO AFFILIATED? <input type="checkbox"/> YES <input type="checkbox"/> NO	POLICY NUMBER	NAME OF INSURANCE AGENT AND PHONE

Everything stated above is true and complete to the best of my knowledge and I agree to notify you of any changes.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_