



phone: 720.898.1110 | fax: 720.898.1113  
www.sfmcolorado.com

NAME OF PATIENT: \_\_\_\_\_  
PATIENT ADDRESS: \_\_\_\_\_ APT # \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_  
HOME PHONE NUMBER: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SEX: \_\_\_\_\_  
SOCIAL SECURITY NUMBER: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_  
EMPLOYER NAME: \_\_\_\_\_ WORK PHONE NUMBER: \_\_\_\_\_  
EMPLOYER ADDRESS: \_\_\_\_\_  
OCCUPATION: \_\_\_\_\_  
EMAIL: \_\_\_\_\_ HOW DID YOU HEAR ABOUT US? \_\_\_\_\_  
PREFERRED PHARMACY \_\_\_\_\_ LOCATION \_\_\_\_\_

RESPONSIBLE PERSON INFORMATION (NAME THE INSURANCE IS UNDER)

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
HOME PHONE NUMBER: \_\_\_\_\_ WORK PHONE NUMBER: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_  
NAME OF EMPLOYER: \_\_\_\_\_  
EMPLOYER ADDRESS: \_\_\_\_\_

PRIMARY INSURANCE INFORMATION

SECONDARY INSURANCE INFO

INSURANCE NAME: _____	_____
POLICY / ID NUMBER: _____	_____
GROUP NUMBER: _____	_____
POLICY HOLDER NAME: _____	_____
COPAYMENT AMOUNT: _____	_____

EMERGENCY CONTACT INFORMATION

NAME: \_\_\_\_\_  
RELATIONSHIP: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

I hereby authorize payment directly to Sports and Family Medicine of Colorado, PC and authorize the release of any medical information to process insurance claims.

I voluntarily consent to examination and treatment for myself and/or my dependent.

I will be responsible for the full amount of the charges except those under Sports and Family Medicine of Colorado PC's contractual arrangements with payors.

SIGNATURE OF RESPONSIBLE PERSON: \_\_\_\_\_

DATE: \_\_\_\_\_