



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: _____
CELL PHONE NUMBER: _____ SOCIAL SECURITY NUMBER: _____
SEX: _____ 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: _____