COLORADO SPINE INSTITUTE

elite regenerative stem cell specialists

Patient Demographics and Insurance

Today's Date _____

Have you been seen by any doctor in our practice before? Yes ☐ No ☐

Patient: _____ ☐ M ☐ F Age____Date of Birth_____
Legal last name first M.I.

Mailing Address_____
Street City State Zip code

Home phone_____Cell_____Social Sec #_____

Email address _____ May we leave a detailed phone message? ☐YES ☐ NO

Preferred method of contact (mark at least one): ☐ Home phone ☐ Cell phone ☐ Email

Employed by_____Occupation_____

Marital Status: ☐ M ☐ S ☐ D ☐ W spouse_____Phone_____

Ethnicity_____Preferred Language _____

Do you consent to receive current and upcoming promotional information? ☐ YES ☐ NO

Person Responsible for Payment (if other than self, complete below)

Name_____Relationship to Patient_____
Last First M.I.

Address_____
Street City State Zip code

Phone_____Employer _____ Business Phone _____

Person to Notify in Case of Emergency (Other than person listed above)

Name_____Relationship_____Phone _____

A. Insurance Information (Current insurance card must be provided at time of check in)

☐ **Primary Insurance** _____ PPO ☐ HMO ☐ OTHER ☐

Policy holder's name_____**Policy holder's DOB:** _____
Policy #_____Group_____Phone _____
Address_____

☐ **Secondary Insurance** _____ PPO ☐ HMO ☐ OTHER ☐

Policy holder's name_____**Policy holder's DOB:** _____
Policy #_____Group_____Phone _____
Address _____

B. Workman's Comp (work injury)

CLAIM NUMBER: _____
Date and Time of Injury_____
Describe your injury in detail: _____
_____
Did you file an incident report: ☐ YES ☐ NO
Any history of previous symptoms or injuries: ☐ YES ☐ NO
If yes, please explain: _____

Any history of previous missed work due to injury: ☐ YES ☐ NO Are you working now: ☐ YES ☐ NO

When was the last time you worked full time: _____ Part time: _____

Do you have any current work restrictions: ☐ YES ☐ NO
If yes, please explain: _____

Detail your job description: _____

Do you have a lawyer working on this claim: ☐ YES ☐ NO
If yes, Name and contact information of lawyer: _____

- **W.C.:** Adjustor/case manager's Name: _____Phone: _____

  Billing Address _____
- **Attorney involved:** Name_____Phone _____
  Billing Address_____

C. Auto Injury

Date and Time of Injury: _____
Describe your injury in detail: _____
_____

Any history of previous symptoms or injuries: ☐ YES ☐ NO
If yes, please explain: _____

Total Lost time from work due to injury: _____ Are you working now: ☐ YES ☐ NO

When was the last time you worked full time: _____ Part time: _____

Do you have any current work restrictions: ☐ YES ☐ NO
If yes, please explain: _____

Detail your job description: _____

Do you have any current work restrictions: ☐ YES ☐ NO
If yes, please explain: _____

Date and time and location of accident: _____
Make and model of car: _____ Amount of damage _____

Other passengers injured in your car: _____
Your position in the car: _____ Seat belt worn: ☐ YES ☐ NO

How accident occurred: _____

Initial treatment at: _____ Did you lose consciousness: ☐ YES ☐ NO

Do you have a lawyer working on this claim: ☐ YES ☐ NO
If yes, Name and contact information of lawyer: _____

- **Adjustor/case manager**: Name_____Phone _____

  Billing Address _____
- **Attorney involved:** Name_____Phone _____
  Billing Address_____