Colorado Orthopedic Consultants, P.C.
1411 South Potomac Street, Suite 400, Aurora, CO 80012
401 West Hampden Place, Suite 220, Englewood, CO 80110

PATIENT INFORMATION

Name: _____

Address: _____

_____

City, State, Zip: _____

Home Phone: (_____) _____

Cell Phone: (_____) _____

Work Phone: (_____) _____

Best number to reach you at: ☐ Home ☐ Cell ☐ Work

ACCIDENT INFORMATION

Was this injury related to an accident? ☐ Yes ☐ No

If yes, was it: ☐ Work Comp ☐ Auto ☐ Other

Injured body part: _____

Claim #: _____

Date of injury: _____

Authorization #: _____

Adjustor's Name: _____

Adjuster's Phone: (_____) _____

Adjuster's Fax: (_____) _____

Attorney's Name: _____

Attorney's Phone: (_____) _____

Attorney's Fax: (_____) _____

☐ Male ☐ Female

Date of Birth: _____

Social Security #: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other

Referral Source: ☐ Physician ☐ Patient ☐ Friend ☐ Other

Referring Physician: _____

Referring Address: _____

City, State, Zip _____

Referring Phone: (_____) _____

Primary Physician: _____

Primary Address: _____

City, State, Zip: _____

Primary Phone: (_____) _____

EMERGENCY CONTACT (NOT LIVING WITH YOU)

Name: _____

Phone: (_____) _____

Relationship: _____

PATIENT EMPLOYMENT

Employer: _____

Employer Address: _____

City, State, Zip: _____

Employer Phone: (_____) _____

PRIMARY INSURANCE

Policy Holder: ☐ Patient ☐ Guarantor ☐ Spouse ☐ Other

Insurance Company: _____

Insurance Address: _____

City, State, Zip: _____

Insurance Phone: (_____) _____

Policy #: _____

Policy Holder: _____

Insured Phone: (_____) _____

Relationship to Patient: ☐ Spouse ☐ Child ☐ Other

Insured Date of Birth: _____

Insured SS #: _____

Group #: _____

SECONDARY INSURANCE

Policy Holder: ☐ Patient ☐ Guarantor ☐ Spouse ☐ Other

Insurance Company: _____

Insurance Address: _____

City, State, Zip: _____

Insurance Phone: (_____) _____

Policy #: _____

Policy Holder: _____

Insured Phone: (_____) _____

Relationship to Patient: ☐ Spouse ☐ Child ☐ Other

Insured Date of Birth: _____

Insured SS #: _____

Group #: _____

PATIENT RELEASE

Release: I hereby consent to the release of information provided to, or generated by COC, to my primary care physician, referring physician, physical therapist, attorney, insurance carrier (s), agency, or other party with a bonafide, pertinent interest via verbal, written, or fax/e-mail communication. A copy or scanned image of my signature shall be valid as the original.

Assignment: I hereby assign medical benefits otherwise payable to me to COC. I understand and agree I am financially responsible for any unpaid balance for services rendered along with legal fees incurred in collecting payment from me. If applicable, I understand I am responsible for all co-pays, deductibles, co-insurance, and balances.

Verification: I hereby verify that all the above information is true and correct as of the date signed below.

Patient Signature: _____ Date: _____

Parent or Legal Guardian if patient is a minor.