

New Patient Information Sheet

Patient should complete all applicable areas; please print.

Patient Number / Chart: _____

PATIENT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (Home & Cell) _____ (Work) _____

Email Address: _____

Birth date: ____ / ____ / ____ Age: ____ Social Security Number: ____ - ____ - ____

Sex: (M/F) _____ Marital Status (S/M/W/D) _____

Preferred Pharmacy: _____ Location: _____

INSURANCE INFORMATION

Name of Policy Holder: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (Home) _____ (Work) _____

Birth date: ____ / ____ / ____ Age: ____ Social Security Number: ____ - ____ - ____

CREDIT CARD INFORMATION (Will only be charged if account left unpaid 90 days)

Name of Card Holder: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Type of Credit Card: Visa _____ MasterCard _____ Discover _____ AMEX _____

Credit Card Number: _____ Exp. Date ____ / ____

Alpenglow Medical, PLLC

1006 Robertson Street / Fort Collins, CO 80524
Phone 970.482.3820 / Fax 970.482.4942
email: question@alpenglowmedical.com

www.alpenglowmedical.com

New Patient Information Sheet continued

EMERGENCY INFORMATION

Name of Contact: _____

Relationship to Patient: _____ Phone Number: _____

HOW DID YOU HEAR ABOUT US? (Check One)

- | | | | |
|----------------------|-----------------------------|--------------------------------|------------------------------|
| _____ DR _____ | _____ FAM - family member | _____ PROF - professional | |
| _____ DR Johnson | _____ FRD - friend | _____ PT - patient | |
| _____ DR Lopez | _____ INS - insurance | _____ PVH - Poudre Valley Hosp | |
| _____ EME - employee | _____ NF - nursing facility | _____ WEB - internet | |
| _____ EMP - employer | _____ NP - newspaper | _____ YPG - yellow pages | _____ NL - not listed, other |

I hereby authorize Alpenglow Medical, PLLC to furnish information to insurance carriers concerning my illness and treatments. I hereby assign to the doctor all payments for medical services rendered to myself and my dependents. I accept financial responsibility for the unpaid balance and authorize Alpenglow Medical, PLLC to charge the above credit card for the balance due. I understand that this authorization will remain in effect for as long as I, or my dependent, remain a patient:

(Signature) Patient or Guardian: _____

Date: _____

Alpenglow Medical, PLLC

1006 Robertson Street / Fort Collins, CO 80524
Phone 970.482.3820 / Fax 970.482.4942
email: question@alpenglowmedical.com

www.alpenglowmedical.com