Demographic Form

Who is your CPHC Provider:

Last Name:	First Name:	MI:
Sex: M F	Birthdate:	SSN:
Street Address:		
City:	State:	Zip:
Home:	Work:	Cell:
Preferred Contact: ❑ Home ❑ Work ❑ Cell		
Preferred Language:		

Race:
- ❑ American Indian /Alaska Native ❑ Asian
- ❑ Black /African American ❑ Native Hawaiian
- ❑ Other Pacific Islander ❑ More than one race
- ❑ White /Caucasian ❑ Other
- ❑ Unreported/Refuse to Report

Ethnicity:
- ❑ Hispanic or Latino
- ❑ Non-Hispanic
- ❑ Refuse to Report
- ❑ Unreported/Refuse to Report

Marital Status:
- ❑ Single
- ❑ Married
- ❑ Divorced
- ❑ Separated
- ❑ Widowed

OTHER FAMILY MEMBERS SEEN BY OUR PRACTICE

	Relationship	Same Insurance?
1.		Y N
2.		Y N
3.		Y N
4.		Y N

RESPONSIBLE PARTY (*if different from patient*):

Last Name _____ First Name _____ MI _____

Sex M F Birthdate _____ SSN _____

Address _____

City _____ State _____ Zip _____

Home _____ Work _____ Cell _____

PRIMARY INSURANCE INFORMATION

Insurance Company _____ Phone _____

Address _____

Group Number _____ Policy Number _____

POLICY HOLDER (*if different from patient*):

Last Name _____ First Name _____ MI _____

Sex M F Birthdate _____ SSN _____

Employer _____ Phone _____

DO YOU HAVE SECONDARY INSURANCE? ❑ **YES** ❑ **NO**

IF YES, SECONDARY INSURANCE INFORMATION

Insurance Company _____ Phone _____

Address _____

_____

Group Number_____ Policy Number _____

IS YOUR VISIT ACCIDENT RELATED? ❑ **YES** ❑ **NO**

If yes, what type of accident? ❑ Auto ❑ Work ❑ Other _____

Date of Accident _____ Case / Claim Number _____

Adjuster's Name _____ Phone Number _____

If work related, has employer been notified? ❑ Yes ❑ No

If yes, employer contact_____ Phone _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: *I hereby authorize payment directly to Colorado Primary Health Care, LLC., the surgical and/or medical benefits available, if any, and authorize release of any medical information necessary to process this and future claims. I understand that if my insurance fails to make a payment, I am ultimately responsible for payment of services rendered.*

Patient / Guardian Signature: _____ Date: _____