Denver Back Pain Specialists, LLC

Patient Information (Please Print)

Date ____/____/____

Patient's Last Name	First Name	Middle	Nick Name

Address (Street)	City	State	Zip Code

Marital Status Circle One Single Married Widowed Divorced	Sex (circle one) Male Female	Date of Birth	Age	Preferred Language	Home Phone

Patient Social Security #	Patient Employer	Employer Address	Work Phone

Race (circle those that apply) or Deny Response Caucasion Black/African American Asian Native American/Alaskan Hawaiian/Pacific Islander	Ethnicity (circle one) Hispanic/Latino Not Hispanic/Latino	Cell Phone

Name, Address, Phone for Primary Care Physician	Referring Physician/How Referred	Patient Email Address

Injury/Illness or Condition Information

Injury related to (circle one) Work Auto Other (describe)	How did Injury Happen?	

Area(s) Affected – Include side(s)	Date of Injury	State Injury Occured

Attorney Information

Attorney Name	Address	Phone

Guarantor or Insured Party (if other than Patient)

Responsible Party's Last Name First Middle Initial	Relationship to Patient	Social Security #

Address (Street, City, State and Zip)	Date of Birth

Responsible Party's Employer	Employer's Address	Work Phone

Spouse/Parent Information

Spouse/Parent Name (Last, First, Middle Initial)	Relationship	Social Security #

Address (Street, City, State and Zip)	Date of Birth

Employer	Employer's Address	Work Phone

Nearest Relative (not living with patient)

Name (First and Last)	City and State	Home Phone	Work Phone	Relationship

Insurance Information

Primary Insurance		Secondary Insurance	
Circle One: HMO PPO POS Work Comp Auto		Circle One: HMO PPO POS Work Comp Auto	
Insurance Company Name		Insurance Company Name	
Insurance Company Address		Insurance Company Address	
Insurance Company Phone Number		Insurance Company Phone Number	
Adjuster Name	Adjuster Phone	Adjuster Name	Adjuster Phone
Policy Holder Name (Last, First, Mid Intl.)		Policy Holder Name (Last, First, Mid Intl.)	
Policy Holders Social Security	Policy Holders Date of Birth	Policy Holders Social Security	Policy Holders Date of Birth
Insured Employer (where employed when injury happened)		Insured Employer (where employed when injury happened)	
Insured Id/Claim Number	Group Number	Insured Id/Claim Number	Group Number

I understand that as a courtesy to me all claims will be filed through my insurance. However, I am ultimately responsible for all fees, regardless of insurance coverage. I authorize Denver Back Pain Specialists, LLC to furnish my insurance carriers any information concerning my illness and treatments and I hereby assign to Denver Back Pain Specialists, LLC all payments for medical services rendered to me or my dependents. A photocopy of this form shall be as valid as the original. I understand that I can withdraw this medical consent at any time by notifying this office in writing.

I HAVE READ THIS INFORMATION THOROUGHLY AND UNDERSTAND IT.

Signature_____ **Date**_____