Michael C. Sparr, MD **Stephen M. Scheper, DO** **Dwight R. Leggett, II, MD**
Phone 719 636 3333 **Fax** 719 636 0025

PATIENT INFORMATION

(Please Print)
First Name ____________________ Middle Initial ______ Last Name ____________________

Address ____________________ City ____________ State ____ Zip ______

Home ______________ Business ______________ Cell ______________

Birthdate ____/____/____ Age ______ Sex ❍ M ❍ F Social Security # ______-____-________

Employer ______________ Occupation ______________ Marital Status ❍ S ❍ M ❍ W ❍ D

******Rule 5010 for health care providers effective 1/1/12: The Dept of Health & Human Services rule 45 CFR Part 162 (CMS-0009F) of the Health Insurance Reform; HIPAA Act, ACS x12 standards, requires all health care providers to report race, ethnicity and language spoken for all patients. This is information we are required to obtain, not information we are individually requesting.******

Race ❍ Asian ❍ Black ❍ Caucasian ❍ Other ❍ Declined Ethnicity ❍ Hispanic ❍ Non-Hispanic ❍ Declined

Language Spoken ____________________

Spouse's Full Name ____________________ Spouse's Employer ____________________

Emergency Contact ______________ Relationship ______________ Phone ______________
(This contact must be a person not residing at the same address)

Primary Care Physician ____________________ Referred By ____________________

Treatment Related to Work Injury? ❍ Yes ❍ No Auto Accident? ❍ Yes ❍ No Date of Injury __________

INSURANCE

Insurance is a method of receiving reimbursement for services rendered by a provider. Having insurance is not a substitute for payment. Many insurance companies have fixed allowances or percentage rates set by your contract with them, not our office. It is your responsibility to pay at the time of service any deductible, co-pays, or co-insurance fees not paid for by your insurance company.

Primary Insurance Co Name ____________________ **Secondary** Insurance Co Name ____________________

ASSIGNMENT OF BENEFITS – SIGNATURE HIPAA REQUIREMENT

I authorize release of all medical information necessary to process my insurance claims that are pertinent to my medical care. I assign all medical benefits for which i am entitled to the above named physician(s), for the services provided in this office, if payment is not rendered at the time of service. A photocopy of this assignment is to be considered as valid as the original.

I understand that my signature verifies that all information provided on this form is true and correct.

Signature of Responsible Party ______________________________ Date ______________