Blue Skies Center for Women
140 Parkside Drive
Colorado Springs, CO 80910
719-471-3471

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Patient Information Form
(Please Print)

Today's Date: / /	**Primary Care Physician**:

Patient Information

Last Name	First Name	Middle	¡ Mr. ¡ Miss ¡ Mrs. ¡ Ms.	Marital Status (Circle One) Single / Mar. / Div. / Sep. / Wid.

Is this your legal name? ¡ Yes ¡ No	If not, what is your legal name?	(Former Name)	Birth Date: / /	Age:	Student? FT PT

Street Address	City	State	ZIP Code	Social Security Number:	Home Phone No.:

P.O. Box (if available):	Occupation:	Employer:	Employer Phone No.:

Spouse's Last Name	First Name	Middle	Birth Date: / /	Social Security Number:	Contact Phone No.:

Occupation:	Employer:	Employer Address:	Employer Phone No.:

Guardian Information (If minor/student)

Father/Guardian's Last Name	First Name	Middle	Street Address	City	State	ZIP Code

Contact Phone No.:	Employer:	Employer Address:	Employer Phone No.:

Mother/Guardian's Last Name	First Name	Middle	Street Address (if different)	City	State	ZIP Code

Contact Phone No.:	Employer:	Employer Address:	Employer Phone No.:

Insurance Information *(Please give your insurance card to the receptionist)*

Please indicate primary insurance:					
Claims Address:					
Subscriber's Name:	Subscriber's SSN:	Birth Date: / /	Group #:	Policy #:	Co-Payment: $
Patient's Relationship to Subscriber: ¡ Self ¡ Spouse ¡ Child ¡ Other:					
Name of Secondary insurance (if applicable):	Subscriber's Name:		Group #:	Policy #:	
Patient's Relationship to Subscriber: ¡ Self ¡ Spouse ¡ Child ¡ Other:					

Emergency Information

Emergency Contact:	Relationship to Patient:	Home Phone No.:	Work Phone No.:

The above information is true to the best of my knowledge. If and when there are changes to my insurance plans, I will notify Blue Skies Center for Women. I consent to and authorize the medical providers of Blue Skies Center for Women to perform healthcare examinations, treatment, and diagnostic testing as deemed medically necessary in their professional judgment.

I hereby consent to and authorize that payment of benefits for healthcare related services are made to Blue Skies Center for Women. This consent specifically authorizes Blue Skies Center for Women to release personal health information to insurers, governmental agencies, and their agents for billing purposes and determination of benefits. I assign any benefits payable for provider services to the provider or organization furnishing the services. I understand that any lab work, pathology, x-ray, and other testing sent to outside providers will be billed separately by the performing office. It is my responsibility to know which providers and services are covered under my insurance plan.

I understand that there is no guarantee of reimbursement or payment from any insurance company or other payor. I acknowledge full financial responsibility for, and agree to pay, all charges of Blue Skies Center for Women and of providers rendering services not otherwise paid by my health insurance or other payor. All charges are due and payable upon receipt of the bill. If payment is not made within 60 days of receipt of the bill a late charge in the amount of $25.00 will be assessed. I agree to pay all reasonable legal expenses necessary for debt collection.

X _____

Patient/Guardian Signature Date