

## Denver Endocrinology Group Health Intake Form

Date: \_\_\_\_\_

Patient First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_ Employer's Name: \_\_\_\_\_

Email Address: \_\_\_\_\_

(For our patient satisfaction surveys! ©)

### Group Health Insurance Information (ALL FIELDS ARE REQUIRED)

**Primary Insurance Name:** \_\_\_\_\_ Customer Services Phone#. \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Phone #: \_\_\_\_\_ Policy Holder Employer: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group/Policy #: \_\_\_\_\_

**Secondary Insurance Name:** \_\_\_\_\_ Customer Services Phone#. \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Phone #: \_\_\_\_\_ Policy Holder Employer: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group/Policy #: \_\_\_\_\_

### Referring Physician Information:

Referring Physician -First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

- We bill your insurance company as a courtesy to you. It is your responsibility to know your benefits, and you are ultimately responsible for payment if a service is not covered. Please be prepared to make a payment or co-payment at the time of service. Thank you

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