FRED SOBEL, M.D.

Please Print the Following Information Date:_____

PATIENT INFORMATION:

Last Name_____ First Name_____ Middle Initial____

Address_____ City_____ State____ Zip_____

Sex_____ Birthdate_____ Age_____ Marital Status_____SSN_____

Home Phone_____ Work Phone_____ Cell Phone_____

Employer_____ Employer Address_____

INSURANCE INFORMATION:

Primary Insurance Company_____

Policy/Subscriber ID_____ Group Number_____ Effective Date_____

Secondary Insurance Company_____

Policy/Subscriber ID_____ Group Number_____ Effective Date_____

IF POLICY HOLDER IS NOT THE PATIENT PLEASE FILL IN THE FOLLOWING:

Policy Holder Name: Last_____ First_____ Initial____ Birthdate_____

SSN_____ Phone Number_____ Relation to Patient_____

Policy Holder's Employer_____ Work Phone_____

Employer Address_____ City_____ State____Zip_____

REFERRED BY:

Physician (Name)_____ Address_____

Yellow Pages____ Denver Post____ Rocky Mountain News____ Other_____

IN CASE OF EMERGENCY:

Name of Person to Contact_____ Phone Number_____

Relation to Patient_____

PLEASE READ AND SIGN THE FOLLOWING

1. I understand and acknowledge that my insurance coverage is a contract between me and my insurance company and that I am personally responsible for all medical expenses incurred during evaluation and treatment by Dr. Fred Sobel-I understand that as a courtesy my insurance carrier will be billed; however, it is my responsibility to follow up on delinquent claims.
2. I understand and agree that IF care with Dr. Fred Sobel requires a PCP referral it is MY RESPONSIBILITY to see that the referral is current PRIOR to receiving care at the office of Dr. Fred Sobel. If no referral is present in advance, I agree to pay for charges at the time service is rendered.

Signature_____Date_____