

FRED GROSSMAN, 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 Grossman-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 Grossman 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 Grossman. If no referral is present in advance, I agree to pay for charges at the time service is rendered.

Signature _____ Date _____