575 Rivergate Lane, Ste 105

Durango, CO. 81301

970-259-3020

Animas Orthopedic Associates

Date:_____

Patient Information

Last Name First Name Middle Initial

Address City State Zip Code

Mailing address if different City State Zip Code

Preferred contact number Home Phone Cell Phone

E-mail Address Marital Status

Social Security Number: _____ - _____ - _____ Date of Birth: _____ / _____ / _____ Sex: ☐ Male ☐ Female

Preferred language: _____ Race: _____ Religion: _____Primary Care Doctor_____

Insurance

What is the name of your insurance provider: ☐ Medicare ☐ Medicaid ☐ BC/BS ☐ Other

Other (Please Specify): _____ Effective Date: _____ / _____ / _____

/

Name of policy holder: Last Name First Name Middle Initial Relationship to Patient

Address of policy holder if not the same as Patient's

City State Zip Code

Phone: (_____) _____ - _____

Social Security Number of Policy Holder: _____ - _____ - _____

Insurance Identification Number: _____ Group Identification Number: _____

Secondary/Supplemental Insurance

Carrier _____ Phone ( ) _____

Address _____ City_____ State_____ Zip _____

Insured's Name _____ Relationship to patient _____

Subscribers date of birth _____ ID# _____ Group# _____

Employer _____ Employers Phone ( ) _____

I hereby authorize the _____ insurance company to pay by check made out and mailed directly to: Animas Orthopedic Associates. I authorize Animas Orthopedic Associates to release any medical information requested by my insurance company to process a claim.

Signed_____

Emergency Contact

Last Name	First Name	Middle Initial
Address		
City	State	Zip Code
Home Phone	Work Phone	Cell Phone
E-mail Address		Relationship

Employment

Status: ☐ Retired ☐ Full-Time ☐ Part-Time ☐ Unemployed Other: _____

Name of Employer (Company Name) / Occupation

Phone Number: (_____) _____ - _____

Address

City State Zip Code

Advance Directives

Date Reviewed: _____ ☐ None ☐ DNR ☐ Living Will ☐ Durable Power of Attorney ☐ HC Proxy

Race:_____ Religion:_____ Primary Language:_____

Do you have a preferred pharmacy?

_____

Address: _____ Phone Number: _____

Who can we share your medical information with (example—family or doctor's office)?

_____ _____

_____ _____

Are there any exclusions?

_____