<u>Powers Medical . 6080 North Carefree . Colorado Springs, CO 80922</u> <u>Patient Demographics</u>

<u>PLEASE I</u>	DO NOT ABBREVIATE ANY INFO	<u>RMATION</u> 100	iay's Date:		
Patient Informat	<u>tion</u>				
First Name:	MI: Last Name:		DOB	AGE	Sex: M F
Address	Cit	у	_State:Zip:_	SSN:	
Home Phone:	Work Phone:	Ce	l Phone:	Mari	tal Status: S M D V
Email:		Employer:			_ Student: FT PT
Emergency Cont	tact:				
Name:	R	Relationship: Pl		one #:	
Insurance Inform	<u>nation</u>				
Primary Insurance	e Name:	Insurance ID #:		Group #	
Claims Address:					
Insurance Subsc	riber (if other than patient)				
First Name:	MI:L	ast Name:		DOB	AGE
Address		City		State:	Zip:
Home Phone:	Work	Work Phone: Cell Ph			
Patients Relationshi	ip to Subscriber:				
Secondary Insur	ance Information				
Secondary Insurai	nce Name:	Insurance ID #:_		Group #	
Address		City		State:	Zip:
Claims Address:					
RESPONSIBLE	PARTY (if patient under 18):	Name:		SSN:_	
DOB:	Phone #:	Relationship to Patient:			
DO/Powers Medical f	any information necessary to process my for services rendered. I understand that l ue to an effort to collect for service rendered.	am financially responsible			
"This information will the privacy laws of HI	l be used only for communication with of IPPA."	our patients and for the provi	sion of health care so	ervices and insurance	billing according to
I certify that the inf	formation given by me is correct. A	photocopy of these assign	nments shall be va	lid as its original.	
Patient Signature	or Legal Guardian	Printed Name		Date	
UPDATES: I ve	rify that the information on th	is form is current an	d unchanged. D	ate/Initials:	
					12/09