Colorado West Otolaryngologists, PC

2515 Foresight Circle, Ste 200
Grand Junction, CO 81505
970-245-2400

100 Tessitore Ct. Ste B
Montrose, CO 81401
970-787-4710

233 Cottonwood St
Delta, CO 81416
970-245-2400

711 N Taylor St
Gunnison, CO 81230
970-787-4710

PATIENT INFORMATION

Patients Last Name	First Name	Middle Initial		
Patients Social Security #	E-mail address			
Mailing Address (Street)	(City,State,Zip)			
Primary Phone	Work Phone	Cell/Other Phone	Sex (Circle One) Male Female	Date of Birth
Referring Physician	Primary Care Physician			
Preferred Language ☐ English ☐ Spanish ☐ Other_____	**Race** ☐ Black or African American ☐ Hispanic ☐ White ☐ Other_____	**Ethnicity**		

PERSON RESPONSIBLE FOR PAYMENT/TO RECEIVE STATEMENTS (If Different From Patient)

Spouse/Parent Last Name	First Name	Middle Initial	Relationship	Social Security #
Cell/Other Phone	Address (Street, City, State And Zip)			

SPOUSE/PARENT LIVING WITH (If not already listed)

Spouse/Parent Last Name	First Name	Middle Initial	Relationship	Social Security #
Date of Birth	Work Phone	Cell/Other Phone		

EMERGENCY CONTACT PERSON (not living with patient)

Name (First and Last)	Home Phone	Relationship

INSURANCE INFORMATION

Primary Insurance Co.	ID#	Group or Plan #	
Insured Party (Subscriber)	**Subscriber's SS#**	**Subscriber's DOB**	**Relationship to patient**
Subscriber's Mailing Address (if different from patient) (Street)	(City,State,Zip)		
Secondary Insurance Co.	ID#	Group or Plan #	
Insured Party (Subscriber)	**Subscriber's SS#**	**Subscriber's DOB**	**Relationship to patient**
Subscriber's Mailing Address (if different from patient) (Street)	(City,State,Zip)		

The information listed above is accurate to the best of my knowledge. I hereby authorize Colorado West Otolaryngologists to disclose all medical records pertaining to me and hereby release Colorado West Otolaryngologists from any liability therefore so long as such records are disclosed in confidence to a hospital, health maintenance organization, managed care organization, health insurance benefit plan, health care entity, professional liability carrier, or peer review body, or the delegated agent of any such entity or body, to verify billing or for the purpose of conducting quality of care review, utilization management review, risk management review, peer review, or other similar activity. I hereby authorize messages regarding appointments with this office to be left on my telephone answering machine or with a family member. I understand that I am ultimately responsible for any of my charges, regardless of insurance coverage. I authorize payment directly to Colorado West Otolaryngologists, P.C. of any benefits payable to me for services rendered.

I understand that there may be a fee for missed appointments or canceled appointments without a 24 hour notice.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have been advised of the Notice of Privacy Practices for Colorado West Otolaryngologists, P.C.

Signature_____ **Date** _____

Patient/Parent/Legal Guardian