FRONT RANGE CENTER for BRAIN & SPINE SURGERY, P.C. 1313 Riverside Ave., Ft. Collins, CO 80524
(970) 493-1292

Registration Information
(Page one)

For office use only:
TCW DMT DWB ________ FC LV CH GO
Date
☐ Yes, interpreter required Language: ________
☐ FRC provides ☐ Patient provides

Full legal name (please print in ink throughout this form)

Maiden or other name | Email address

Address: Street (if P.O. Box, please include street address) | City | State | Zip Code

( ) Telephone—If none, please list one of friend or relative | ( ) Cellular phone number | ( ) Work phone (list work hours)

Single ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Legally separated** ☐ **Significant other** ☐

(Please check the patient's current marital status above)

Birth date | Age | Sex (check one) M ☐ F ☐ | Patient's Social Security (SS) number

If the patient is a minor under 18 years old, please provide information for the parent, guardian, or person responsible for payment

Name | Relationship | Address | City | State | Zip Code

( ) Phone number—home | ( ) Phone number—cell | ( ) Phone number—work | Social Security (SS) number

Name of spouse/partner: ________

Spouse's/partner's employer: ________

Spouse's/partner's work address: ________

Spouse's/partner's work phone number: ( ) ________ | ________ Spouse's/partner's Social Security number

Emergency contact: ________
Name | **Relationship** | ( ) **Phone days** | ( ) **and evenings**

Employment Information

Employer's name: ________

Your present occupation: ________

Work address: ________

Work phone: ( ) ________

Referring physician: ________ ( )
(Please be specific) First name | Last name | Phone number

Address: ________

Primary physician: ________
First name | Last name

Address: ________ ( )
Phone number

I learned about your practice from (please check all that apply):

☐ my own doctor or my referring doctor ________
☐ a family member, friend, or acquaintance ☐ my insurance company/insurance adjustor
☐ the Yellow Pages or similar directory ☐ the Front Range Center for Brain & Spine Surgery website
☐ an ad by Front Range Center for Brain & Spine Surgery (FRB&S) ☐ an email from FRB&S
☐ the reputation of FRB&S ☐ other ________

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Registration Information (Page two)

Name (please print) ____________________

Insurance Information

Primary Carrier

Company name: ____________________ Group no. ____________________

Co.'s address: ____________________ Co.'s phone: (   ) ____________________

Subscriber's name: ____________________ Date of birth: ____________________ Relationship: ____________________

Policy or claim number: ____________________ Written referral required? ☐ Yes ☐ No

Secondary Carrier

Company name: ____________________ Group no. ____________________

Co.'s address: ____________________ Co.'s phone: (   ) ____________________

Subscriber's name: ____________________ Date of birth: ____________________ Relationship: ____________________

Policy or claim number: ____________________ Written referral required? ☐ Yes ☐ No

Automobile Accident Information

Describe the accident: ____________________ State where accident occurred ____

Claim number: ____________________ Date of injury: ____________________

Insurance company: ____________________ Co.'s phone: (   ) ____________________

Insurance company address: ____________________

Is this your auto insurance, or a third party's insurance? ____________________
Mine   Name of third-party insurer

Adjustor: ____________________

Workers' Compensation Information

Your employer when injured: ____________________

Claim number: ____________________ Date of injury: ____________________

Insurance company: ____________________ Co.'s phone: (   ) ____________________

Insurance company address: ____________________

Adjustor: ____________________

Legal Information

Are you contacting an attorney(s) to help you in litigating a personal injury, auto accident, or Workers' Compensation suit? If yes, please give attorney's or attorneys' name(s), phone number, and address.

____________________ (   ) ____________________
Name   Phone number

____
Address

Assignment of Benefits

I hereby assign all medical and/or surgical benefits associated with this office, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to the Front Range Center for Brain & Spine Surgery, P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. **I hereby agree to pay any and all charges that exceed or that are not covered by insurance.** I hereby authorize said assignee to release all information to secure the payment. To ensure continuity of care, I hereby authorize the release of all medical records to my primary and referring physicians. I hereby release copies of this information sheet to any hospital I may be admitted to. I also authorize Medicare, private insurance, and any other health plan to furnish said assignee any information regarding payment of my claim.

X ____________________
Signature   Date