

# South Denver Orthopedics

## Brian E. H. Reiss, M.D.

### NEW PATIENT INFORMATION

Please PRINT and COMPLETE ALL INFORMATION

#### PATIENT INFORMATION

Today's Date: \_\_\_\_\_

Is your visit related to a legal case?  Yes  No

Are you planning to apply for disability?  Yes  No

Patient Name: \_\_\_\_\_ How would you like to be addressed? \_\_\_\_\_

Address: \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Marital Status:  Married  Single  Widowed  Partner Spouse's Name: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_

#### PHYSICIAN INFORMATION

Referring MD: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Current Pharmacy Phone#: \_\_\_\_\_ Do we have permission to download your RX's? \_\_\_\_\_

#### NOTIFY IN CASE OF AN EMERGENCY

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home phone: \_\_\_\_\_ Work: \_\_\_\_\_

#### INSURANCE

Please have your insurance card(s) ready and available. We will be scanning this information into our system to bill your insurance for services rendered.

Primary Insurance Company:		Secondary Insurance Company:	
Policy Holder (If different than patient)	<input type="checkbox"/> SELF	Policy Holder (If different than patient)	<input type="checkbox"/> SELF
Name: _____		Name: _____	
Date of Birth: _____		Date of Birth: _____	
SSN# _____		SSN# _____	

Is this a work related injury? Yes No  
\*Injury Date: \_\_\_\_\_

Is this an auto related injury? Yes No  
\*Injury Date: \_\_\_\_\_

I authorize payment of medical benefits to physician or supplier for these services and all future claims.

**X:** \_\_\_\_\_  
Signed (Insured or Authorized Representative)

Patient Name \_\_\_\_\_ Date \_\_\_\_\_ Physician's Initials \_\_\_\_\_