



Douglas E. Hemler, M.D. *Board Certified PM&R, Pain Medicine, Electrodiagnostic Medicine*
 Kyle C. Morgan, D.O. *Board Eligible PM&R, Pain Medicine, Electrodiagnostic Medicine*
 Kirk Prochnio, P.A.-C.

SPINE AND SPORT

Please Print!!

Patient Legal Name (First MI Last)		Patient SS#		Patient Date of Birth	
Nickname	<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Address		Home Phone#		Work Phone#	
City, State, Zip		Other #		Cell #	
Employer	Occupation	Race	Ethnicity	Preferred language	

Collection of race, ethnicity, and language data would allow stratification of quality measures in physician practices to create awareness of differential practice patterns or response among patient populations and accordingly identify opportunities for quality improvement. The ARRA provision for "meaningful use" of EHRs applies to enabling the exchange of health information and reporting on clinical quality measures to CMS, medical boards, private plans, and others.

I. Please list the family members or other persons (doctor, attorney, nurse case manager, adjuster, etc), if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

II. Please list the family members or significant others, if any, whom we may inform your medical condition **ONLY IN AN EMERGENCY**:

Name _____ Phone _____

V. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number:

() _____

* **I am fully aware that a cell phone is not a secure and private line.**

** **I am fully aware my health information can be transmitted by facsimile (fax), mail or the internet.**

VI. Can confidential messages (i.e. appointment reminders) be left on your home answering machine or voicemail?

YES _____ NO _____

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

Insurance Information – Financial Responsibility Statement: *Please present insurance cards to be copied.*

	Primary Insurance	Secondary Insurance
Insurance Name		
Mailing Address for Claims		
Insurance Phone #		
Insured's Name		
Insured Relationship to Patient	<input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other	<input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other
Group Name/Group #		
Policy #		
Is preauthorization required for office visits, diagnostic tests, hospitalization and/or surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Nonsurgical Orthopedics, Interventional Spine Procedures, Sports Medicine, Electrodiagnosis, Occupational Medicine, Pain Management, Rehabilitation

2801 Youngfield Street
 Suite 150
 Golden. CO 80401

303-238-4277
 Fax: 303-238-4977
 www.starcolorado.com