

**Colorado Reproductive Endocrinology**

4600 E. Hale Parkway, Suite 350  
Denver, Colorado 80220  
(303) 321-7115

**PATIENT INFORMATION**

Date: \_\_\_\_\_

\_\_\_\_\_  
First Name M.I. Last Name

\_\_\_\_\_  
Street Address City State Zip Code

\_\_\_\_\_  
Social Security No Date of Birth Home Phone

\_\_\_\_\_  
Employer Work Phone

\_\_\_\_\_  
Primary Care Physician Referring Physician

**SPOUSE/PARTNER INFORMATION** (If Applicable)

\_\_\_\_\_  
First Name M.I. Last Name

\_\_\_\_\_  
Social Security No Date of Birth

\_\_\_\_\_  
Employer Work Phone

**NEXT OF KIN INFORMATION:** Please give the name of nearest relative, not living with you, to contact in case of an emergency.

\_\_\_\_\_  
Name/Relationship Home Phone

**INSURANCE INFORMATION:**

\_\_\_\_\_  
Patient Primary Insurance Patient Secondary Insurance

\_\_\_\_\_  
Policy Holder Policy Holder

\_\_\_\_\_  
Group Number Group Number

\_\_\_\_\_  
ID# Address: ID# Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Insurance Phone Number Insurance Phone Number

I am aware that I may inquire of my health provider the fee(s) for the professional services required and/or rendered. I authorize payment of all medical benefits to the assigned physician for these services and all future claims. I also authorized Colorado Reproductive Endocrinology to release any medical information to process this claim and any future claims.

\_\_\_\_\_  
Patient Signature

I further authorize Colorado Reproductive Endocrinology to release results of any test to my spouse/partner **YES or NO**

\_\_\_\_\_  
Patient Signature