CENTER FOR MINIMALLY INVASIVE SURGERY
SERVING SOUTH METRO DENVER

David J. Lundy, M.D.
2352 Meadows Blvd. #220, Castle Rock, CO 80109
p: 303-814-8138 f: 303-814-8139
www.DavidLundyMD.com

PATIENT INFORMATION

Referring Physician*_____ or *Other referral: *Friend/Family Hospital Internet*

Primary Care Physician (if different) _____

Last Name: _____ ***First:*** _____ ***M.I.*** ____ ***Nickname***_____

Sex: M F ***Marital Status:*** S M W D ***SSN:*** _____ ***Date of Birth*** _____ ***Age***_____

Street Address: _____ ***City:*** _____ ***State*** _____ ***Zip*** _____

Home Ph. _____ ***Cell Ph.*** _____ ***Work Ph.*** _____

Race: _____ ***Ethnicity***: _____ ***Language Spoken at Home*** _____

Yes, please enroll me in the patient portal for secure communications and access to my medical information: _____ (initial)

Email Address: _____ ***I authorize this office to contact me via email: Yes No***

Employment Status: Employed Unemployed Self-Employed Student Active Military Retired Disabled

Employer: _____ ***Employer Address:*** _____ ***Employer Ph:*** _____

Spouse/Guardian Name _____ ***Home Ph (if different)*** : _____ ***Cell*** _____

Address (if different) _____

Emergency Contact: (A relative or friend <u>not living with you</u>) Name _____ ***Ph.*** _____

Address _____***Relationship:*** _____

If accident: N/A Workers' Comp Auto Other **Date of Injury** _____

<u>If you are not the primary subscriber on your insurance, please provide the following information:</u>

Primary Subscriber's Name_____ ***and DOB*** _____ ***Relationship*** _____

You will be asked to present your insurance card and identification at the time of service.

I understand that I am responsible for all charges. I will furnish this office with all information necessary to bill my insurance. Any balance after insurance has paid or denied is due by me. I agree that if it becomes necessary to forward my account to a collection agency I will also be responsible for the reasonable cost of collection, to include attorney fees. I understand that my insurance benefits and referral requirements are my responsibility and that all copayments are due at the time of service.

I authorize payment of medical benefits to physician for these services and all future claims and I authorize the release of any medical information necessary to process this claim and all future claims.

*X*_____ *(signed)* Date: _____