755 South Perry Street, Suite 100
Castle Rock, CO 80104
303-688-8989 Fax: 303-688-3482

Castle Rock Family Physicians

New Patient Registration Form

Please fill out this form and bring it with you to your appointment. Also, please bring your insurance card, co-payment and deductible (if applicable).

PATIENT INFORMATION:

Patient Name: _____ Today's Date:_____

Patient Social Security No: _____ Drivers License State / #: _____

Address: _____ Occupation: _____

_____ Employer: _____

City / State / Zip: _____ Employer Address:_____

DOB: _____ Age: ____ Gender: Male___ Female___ City / State / Zip: _____
Marital Status: S M D W Race:_____ Ethnicity:_____ Preferred Language:_____

Please fill out all contact information below; part of this is to send you your appointment notice:

Home Phone:_____Cell:_____ Work:_____Email:_____

Emergency Contact: _____ Relationship: _____ Phone No: _____

SPOUSE or PARENT INFORMATON:

Name: _____ Relationship: _____

Address: _____ Social Security No: _____

City / State / Zip: _____ Employer: _____

Date of Birth: _____ Work Telephone No. _____

PHONE MESSAGE CONSENT:

☐ **No, do not leave me any voice messages regarding my medical results but I agree to everything else below:**

☐ **Yes, I authorize the following:**

Castle Rock Family Physicians, has my permission to leave a message regarding my medical care, billing information, lab and / or test results on the following telephone number/s for date of service _____ with Spouse or Significant Other _____. I authorize Castle Rock Family Physicians to leave a message at the phone number/s below thru end date _____.

Preferred phone number to contact me (circle one) Cell Home Work

Spouse / Significant Other:_____

_____ _____
Signature (or Parent Signature if Patient is a Minor) Date

Please continue to Page 2

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INSURANCE INFORMATION: **Please give your insurance ID card to our receptionist to photocopy.**
Please note that we will bill secondary insurance one time only.

Primary Insurance Company: _____
Policyholder's Name: _____ Relation to Patient: _____

Secondary Insurance Company_____
Policyholder's Name: _____ Relation to Patient: _____

Who may we thank for referring you to our practice? _____

PLEASE UPDATE YOUR INFORMATION WITH THE RECEPTIONIST STAFF WHENEVER IT CHANGES
I AUTHORIZE Castle Rock Family Physicians to use, disclose and release my Protected Health Information (PHI) for the purpose of carrying out Treatment, Payment, or healthcare Operations (TPO) according to The Privacy Rule of our Federal Government during all visits to The Practice. I understand that I have a right to review the Practice's Privacy Notice, request restrictions and to revoke my consent in writing at any time. Additionally, I authorize the physician to discuss my treatment with other doctors and professionals involved in my treatment.

And,

I AGREE TO PAY for any requested healthcare provided to me by the Castle Rock Family Physicians at the time any services are rendered for non-HMO insurance. I understand that managed care HMO's, Point-Of-Service and Preferred Provider Organization health plans may have co-pays that I am responsible for when services are rendered to me and I agree to pay these on the day of service. I authorize payment directly to Castle Rock Family Physicians for any insurance benefits.

And,

AUTHORIZATION TO TRANSMIT MEDICAL INFORMATION ELECTRONICALLY: By signing this, you are agreeing to have medical information regarding your medical care with Castle Rock Family Physicians transmitted electronically in a highly secure and encrypted manner. This information is transmitted using HCFA and HIPPA healthcare guidelines for transmission to the parties authorized by you for your paper or electronic record to receive your health insurance claim.

_____ _____
Date **Patient / Parent Signature as agreed to above**

MINOR'S CONSENT: I permit my healthcare provider to allow my parents access to my medical record.

_____ _____
Date **Minor 12 to 21 years of age sign here if you agree to the above statement.**