

# Welcome To Our Office

*The Care Group, P.C.*

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Aurora, CO 80011

303-343-3121 FAX: 303-343-3514

www.thecaregrouppc.com

PLEASE PRINT and COMPLETE ALL PARTS

Patient Number \_\_\_\_\_

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

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## PATIENT INFO: (This section refers to PATIENT ONLY)

Name \_\_\_\_\_ Referred By \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email Addr \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Social Security # \_\_\_\_\_

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

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

Relationship to Responsible Party:    Self    Spouse    Son    Daughter    Other

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## RESPONSIBLE PARTY: (Person who should receive the bill)

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Auto Injury / Work Comp (circle)    Claim # \_\_\_\_\_    Date of Accident \_\_\_\_\_

Other Injury (specify) \_\_\_\_\_    Date of Accident \_\_\_\_\_

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This space for office use only.

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## NOTIFY IN EMERGENCY: (NOT LIVING WITH YOU)

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

PLEASE SIGN  
BY BOTH X'S

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

**X** \_\_\_\_\_

Signed (Insured or Authorized Person)

I authorize the release of any medical information  
necessary to process this claim and all future claims.

**X** \_\_\_\_\_

Signed (Insured or Authorized Person)