209 Main st, Unit E
Mead, CO 80542
Phone: (970)535-9900 Fax: 1-888-915-3313
E-Mail: info@alcmc.com Web: www.alcmc.com

Thank you for choosing our clinic for your health care needs. We are very happy you are here. In order to serve you to the best of our ability, we will need you to complete the following patient information and answer all questions on the subsequent questionnaires. We use this information to know you better and to file insurance for you, if applicable. Please be patient in providing us all the necessary information. We want you to reach your health care goals, so please be complete with your answers. **Again, Thank You!**

PATIENT INFORMATION

Date:_____

Patient Name:_____

Address:_____

_____
City ST ZIP

Sex: M F Age:_____ Birthdate:___/___/____

___Single ___Married ___Divorced ___Separated ___Widowed

Occupation:_____

Employer:_____

Employer Location:_____

Employer Phone:_____

Spouse's Name:_____

Spouse Birthdate:___/___/_____ Occupation:_____

Spouse's Employer:_____

Provide Name & Location of Your Primary Care Physician:

_____

How Did You Hear About Us?

__Personal Referral Name:_____

__Internet Web Address:_____

__Phone Book

__Advertisement Where:_____

__Our Location

__Other Please Describe:_____

CONTACT INFORMATION

Home #: (____)____-_____ Work #: (____)___-_____

Cell #: (____)____-_____ **e-mail:**_____

Best Time/Place to reach you_____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name_____ Best #: (____)____-_____

INSURANCE INFORMATION

Who is Responsible for this account?_____

Relationship to patient (Self, Spouse, etc.)_____

Insurance Company:_____

Group #:_____

Member # or ID:_____

Subscriber's Name:_____

Birthdate:___/___/_____ SS#:_____

Is the patient covered by additional insurance? __Yes __No

Relationship to patient (Self, Spouse, etc.)_____

Insurance Company:_____

Group #:_____

Member # or ID:_____

Subscriber's Name:_____

Birthdate:___/___/_____ SS#:_____