***Welcome To Our Office***

**PLEASE PRINT and COMPLETE ALL PARTS**

EARL J. CARSTENSEN, MD
2281 South Peoria
Aurora, Colorado 80014
Phone: (303)696-9300
Fax: (303)696-9281

Name of Patient______________________________________________

Address______________________________________Apt.__________________

City________________State________________Zip________________

Home Phone_______________ Work Phone________________ Cell Phone__________________

Which should we use to leave messages for appointment reminders, lab results, or medical information?

☐ Home Phone ☐ Work Phone ☐ Cell Phone

Date of Birth_________________ Gender______________ Social Security #___________________________

May we use E-mail for communicating lab results & other medical information? Y N

If yes, E-MAIL Address ______________________________________________

How did you find our practice? ______________________________________________

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**RESPONSIBLE PARTY: (Person who holds insurance)**

Name _______________________________________Relation to Patient_____________________________

Address________________________________City______________State____________ Zip_____________

Home Phone_______________ Work Phone_______________ Social Security #_______________________

Date of Birth________________ Employer______________________________________________

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**INSURANCE: (We will need a copy of your insurance card.)**

Primary Insurance______________________________ Secondary Insurance___________________________

Address__________________________________ Address______________________________________

City, State, Zip_______________________________ City, State Zip__________________________________

Phone: Area ( ) __________________ Phone: Area ( ) ____________________________

Primary Insured Person_______________________ Primary Insured Person__________________________

ID/Policy #___________________ Suffix__________ ID/Policy #________________ Suffix________________

Group #________________________________ Group #______________________________________

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**I herby acknowledge that I have received Healthy Practices' Notice of Privacy Practices.**

**I authorize payment of insurance benefits otherwise payable to me directly to the physician. At the time of service, or when notified, I will pay in full all charges designated as my responsibility by my insurance carrier. When notified, I will pay in full any and all charges incurred when insurance was not in effect.**

_______________________________ ______________________________________

**Signature of Patient**
**(Or Patient's Representative)**

**Date**