Dianne C Stone MD, PC
6870 W. 52nd Avenue, #210, Arvada, CO 80002

PATIENT INFORMATION

Last Name_________________________________ First Name ______________________________ MI______

Address__________________________________Apt #:______ City _________________ State_____ Zip ________

Social Security Number _________-______-______________ Date of Birth _____________/_____/____________

Check One: ☐Single ☐Married ☐Common Law ☐ Separated ☐Divorced ☐Widowed ☐Partner

Home Phone________________________________Work Phone_______________________________________

Cell Phone_________________________________Email Address_____________________________________

Employer____Occupation_________________________

Name of Primary Care Physician ____

How did you hear about our office? ☐ Referred here by another doctor Name______________________________
☐ Referred by friend __________________________________ ☐ Internet search ☐ Magazine ☐ Insurance book

Emergency Contact: Name__________________________________ Relationship to patient______________________
Home Phone______________________Work Phone_______________________Cell Phone___________________

BILLING INFORMATION-PLEASE FILL OUT ALL NECESSARY FIELDS!!!

Primary Insurance; How is the patient related to the insured? ☐Self ☐Spouse☐Child

1) Insured Name____Date of Birth_________________

Employer's Name_______________________________________ Phone_________________________

Address_____________________________City____________________State______Zip____________

2) Insurance Identification #______________________________Group #___________________________

Insurance Company Name_____________________________________Phone____________________

Address__________________________________City________________State______Zip___________

Secondary Insurance; How is the patient related to the insured? ☐Self ☐Spouse☐Child

1) Insured Name____Date of Birth_________________

Employer's Name____ Phone____________________

Address_____________________________City____________________State______Zip____________

2) Insurance Identification #_________________________________Group #_________________________

Insurance Company Name_______________________________________Phone___________________

Address__________________________________City________________State______Zip___________

☐ **SELF PAY-NO MEDICAL INSURANCE**

I hereby authorize payment of insurance benefits be made to Dianne C. Stone, MD, PC and any assistants, for services rendered. I understand that I am financially responsible for payment of any charges that are not covered by insurance, including co-payments, deductibles, co-insurance, and non-covered services. In the event of default, I will be responsible for payment of all collection costs and any associated attorneys fees. I further authorize Dianne C. Stone, MD, PC to release all information to secure the payment of benefits on my behalf. I agree that a photocopy of this signed agreement will be as valid as the original.

Patient Signature____Date__________________________