South Denver Internal Medicine
A Concierge Medical Practice at Sky Ridge Medical Center
Charles H. Miranda, MD, FACP

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Patient Information (please print clearly with full detail)

Today's Date				
Patient's Last Name:	Patients First Name:	Middle Initial:		
Street Address and Unit #:	City & State	Zip Code:		
Patient Home Phone:	Patient Work Phone:	Patient Cell Phone:		
Female [ ] Male [ ]	Date of Birth:	Age:	Patient's Social Security #:	CO Drivers License #
Patient's Occupation:	Patient's Employer and Address:			
Marital Status: Married [ ] Single [ ] Divorced [ ]	Spouse Name and Phone:			
Email Address:				
Who referred you?	Briefly state the reason for today's visit:			
Your Pharmacy name and Location:	Emergency contact of someone not living with you: Name: Phone: Relationship:			
Primary Insurance:				
Name and address of Primary Insured's Employer:	Primary Insured's Name:			
Member or ID # (usually Social Security # of person insured):				
Primary Insured's Relation to Patient:	Primary Insured's DOB:	Primary Insured's Social Security #:		
Primary Ins. Co Mail Claims to Address (on back of insurance card):	Primary Ins. Co Group #:	Primary Ins. Co Phone # (claims or benefits):		
Secondary Insurance:				
Name and address of Secondary Insured's Employer:	Secondary Insured's Name:			
Member or ID # (usually Social Security # of person insured):				
Secondary Insured's Relation to Patient:	Secondary Insured's DOB:	Secondary Insured's Social Security #:		
Secondary Ins. Co Mail Claims to Address (on back of insurance card):	Primary Ins Co Group #:	Primary Ins. Co Phone # (claims or benefits):		

RELEASE & ASSIGNMENT OF BENEFITS: I certify to the accuracy of the above patient information and understand that I am personally responsible for the full amount of my charges regardless of insurance coverage. I hereby authorize the release of any and all medical information to my insurance carrier(s) or it's /their representative, for purposes necessary in the adjudication or processing of any and all insurance claim(s) filed on my behalf and for which I am financially responsible. I further authorize all insurance benefits be paid to the provider rendering services on behalf of South Denver Internal Medicine and Pediatrics, PC.
CONSENT TO TREAT: I herby consent to treatment by my physician.

_____ _____
Patient's Signature (Parent if Patient is a minor child): Date: