

New  Update  
 Cash  Insurance

Gelman  Bock  Petrak  
 Boulder  Longmont  Louisville

**BOULDER VALLEY ASTHMA & ALLERGY CLINICS, PC.**  
**\*\*\*PLEASE COMPLETE EVERY FIELD FULLY\*\*\***

Date: \_\_\_ / \_\_\_ / \_\_\_

**PATIENT INFORMATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_ / \_\_\_ / \_\_\_ Patient's Soc. Sec. No.: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Sex: Male Female Is the Patient? Minor Single Married Is the Patient currently employed? Yes No  
Employer: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

If you circled Minor or Married, please complete the information below.

**\*\*\*WE CAN DISCUSS THE ACCOUNT ONLY WITH THE PATIENT  
AND THOSE LISTED BELOW FOR MINORS\*\*\***

Parent #1/Spouse/Guardian Full Name _____	Parent #2/Spouse/Guardian Full Name _____
Mailing Address _____	Mailing Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Phone: (H) ( ) _____ - _____	Phone: (H) ( ) _____ - _____
(W) ( ) _____ - _____ Ext. _____	(W) ( ) _____ - _____ Ext. _____
(C) ( ) _____ - _____	(C) ( ) _____ - _____
Date of Birth: ___ / ___ / ___	Date of Birth: ___ / ___ / ___
Soc Sec # _____ - _____ - _____ Employer: _____	Soc Sec # _____ - _____ - _____ Employer: _____

**REFERRING PHYSICIAN**

Patient's Referring Physician? Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

**INSURANCE INFORMATION**

**PATIENT'S PRIMARY HEALTH INSURANCE**

Insurance Company \_\_\_\_\_  
Ins. Co. Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Policy Holder: \_\_\_\_\_  
First Name M.I. Last Name  
Date of Birth: \_\_\_ / \_\_\_ / \_\_\_  
Soc Sec # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (Needed for Great West Insurance)  
ID # \_\_\_\_\_ Group # \_\_\_\_\_  
Insurance Effective Date: \_\_\_\_\_

**PATIENT'S SECONDARY HEALTH INSURANCE**

Insurance Company \_\_\_\_\_  
Ins. Co. Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Policy Holder: \_\_\_\_\_  
First Name M.I. Last Name  
Date of Birth: \_\_\_ / \_\_\_ / \_\_\_  
Soc Sec # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (Needed for Great West Insurance)  
ID # \_\_\_\_\_ Group # \_\_\_\_\_  
Insurance Effective Date: \_\_\_\_\_

I authorize the release of any medical information necessary to process this claim and all future claims. I authorize payment of medical benefits to Boulder Valley Asthma & Allergy Clinics, PC for these and all future services. I hereby authorize Boulder Valley Asthma & Allergy Clinics, PC to disclose all medical records pertaining to the above named patient and hereby release Boulder Valley Asthma & Allergy Clinics, PC from any liability therefore so long as such records are disclosed in confidence to a hospital, health maintenance organization, managed care organization, health insurance benefit plan, health care entity, professional liability carrier, or peer review body, or the delegated agent or any such entity or body, to verify billing or for the purpose of conducting quality of care review, utilization management review, risk management review, peer review or other similar activity.

X \_\_\_\_\_  
(Signed Insured or Authorized Person)