New Pueblo Medicine
Your Physician Team for Life

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Patient Registration

Name: _____ Name Preference: _____
(last name) (first name) (middle initial)

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Email: _____

Alternate Phone_____ Birth date: _____

Employer: _____

Gender:

❒ Male ❒ Female ❒ Identifies As _____

Race:

❒ American Indian or Alaskan Native ❒ Asian ❒ Black or African American
❒ Native Hawaiian or Other Pacific Islander ❒ Decline to Specify ❒ White
❒ Other _____ ❒ Two or more races ❒ Decline to specify

Ethnicity:

❒ Decline to Specify ❒ Hispanic or Latino ❒ Not Hispanic or Latino
❒ Unknown/Not Reported ❒ Other _____

Marital status:

❒ Single ❒ Married ❒ Widowed ❒ Separated ❒ Divorced

Language preference: _____

Whom may we thank for referring you? _____

In case of emergency, who should be notified? _____

Phone: _____

Primary Insurance

Name of primary insured: _____
(last name) (first name) (middle initial)

Relation to patient: _____

Address *(if different from patient)*: _____

City _____ State: _____ Zip: _____ Phone: _____

Insurance Company: _____ Effective date: _____

Insurance address: _____

City _____ State: _____ Zip: _____

ID # _____ Group: _____

Additional Insurance

Is patient covered any additional insurance? ❒ Yes ❒ No

Subscriber name: _____

Birth date: _____ Relationship to patient: _____ Phone: _____

Address *(if different from patient)*: _____

City _____ State: _____ Zip: _____ Phone: _____

Insurance Company: _____ Effective date: _____

Insurance address: _____

City _____ State: _____ Zip: _____

ID # _____ Group: _____

Assignment & Release

It is my responsibility to pay the physician for his/her services. I understand that payment is due when services are rendered. I also understand that New Pueblo Medicine – Optum Care will file insurance claims for services rendered to commercial insurance companies, Medicare, HMO and PPO companies according to contract and Worker's Compensation carriers. I authorize release of medical information for insurance claims purposes and authorize payment of insurance benefits to New Pueblo Medicine. I understand that I am responsible for paying the balance of my bill and recovering that payment from my insurance company if my New Pueblo Medicine bill has not been paid by them after 60 days. I understand that I am responsible for attorney fees and court costs associated with collection procedures.

Signature: _____ Date: _____

I authorize New Pueblo Medicine to leave diagnostic test results and other personal health information on my answering machine at home.

Signature: _____ Date: _____

My signature below serves as written authorization to release test results to me personally.

Signature: _____ Date: _____