

Lovitt Gynecology & Women's Health

7150 E Hampden Ave, Suite 202

Denver, CO 80224

P: 720-536-4394 F: 720-536-4397

PATIENT INFORMATION

Patient Name: _____ **DOB:** _____

Email Address: _____ (REQUIRED, Our electronic records program will email you appointment reminders)

(Government Required) Ethnicity: American Indian, Native Hawaiian/Other Pacific Islander, Asian, Hispanic, Black/African American, Caucasian/White, Other _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone #: _____ **Cell #** _____ **Work #:** _____

Yes No to leave you confidential voice mails on your home phone/cell phone

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name: _____ **Relationship to patient** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone #: _____ **Other Phone #:** _____

PRIMARY INSURANCE INFORMATION (If insured is different than patient or guarantor please include DOB)

Insurance Company: _____ **ID#** _____ **Group#:** _____

Copay Amount: \$ _____ **Effective Date of Insurance:** _____

Subscriber Name: _____ **DOB:** _____

Address if different from patient: _____

City: _____ **State:** _____ **Zip:** _____

Phone #: _____ **Other Phone #:** _____ **Relationship to Patient:** _____

Subscriber employer: _____

I hereby authorize my insurance carrier to pay directly to Lovitt Gynecology & Women's Health, realizing I am responsible to pay non-covered services and hereby authorize the release of pertinent medical information to my insurance carrier.

Signature

Date
