Conrad J. Tirre, MD Patient Registration Form

Today's Date:_____

Patient Information

First Name	Middle Name	Last Name

Sex (circle one) Male Female	Marital Status (circle one) Single Married Divorced Widowed	Date of Birth:	Social Security Number (MUST HAVE FOR INSURANCE):

Patient's Address:	City	State	Zip

Home Number:	Cell Phone Number:	Work Number:	Ok to leave a message?

Occupation:	Employer:	Referred by:	

Responsible Party for Billing (Guarantor)

First Name	Middle Name	Last Name

Sex	Marital Status	Date of Birth	Social Security Number

Address	City	State	Zip

Home Phone	Cell Phone	Work Number	Ok to leave a message?

Primary Medical Insurance/Work Comp Insurance/Auto Insurance

Insurance Company Name:	ID # or Work Comp Claim #	Group #

Street Address	City, State, Zip	Phone #

Name of Insured:(MUST HAVE name, SSN, DOB to bill)	Social Security #	Insured's Date of Birth:

***Work Comp and Auto Insurance Only*:** **Date of Accident:** **Work Comp Company and Adjuster:**

Secondary Medical Insurance

Secondary Insurance Name: **ID#** **Group #**

Street Address	City, State, Zip	Phone #

Name of Insured:	Social Security #	Insured's Date of Birth:

Emergency Contact Information

Name	Relationship	Phone #

Address	City	State	Zip

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FINANCIAL CONSENT

I, the responsible party, hereby agree to pay all the charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization, with which this office has a contractual agreement, I agree to pay all applicable co-payments, co-insurance and deductibles, which arise during the course of treatment for the patient. Patients covered under a managed care program are responsible for complying with their insurance rules regarding referrals from primary care physicians to see specialists. Failure to comply with your insurance requirements will result in our office billing you directly for all charges incurred during a non-referred, non-covered visit. The responsible party agrees to pay for treatment(s) rendered to the patient, which is not considered to be a covered service by my insurer and/or a third party insurer, out-of-network provider, or other payer. I furthermore agree to pay a $20.00 Transworld collection fee if the account is assigned to them for collection, and any legal fees/additional collection fees incurred to collect any amount I may owe.

Patient Signature:_____ Date: _____

State Required Ethnicity and Race Questionnaire

Colorado law requires the Colorado Health Care Information Council to collect information on the race/ethnic backgrounds of patients. Physician offices are required to ask patients to identify their own race and ethnic backgrounds.

Nationality or Ethnic Background

Please indicate below the line which most accurately identifies your ethnic background.

_____ Hispanic/Latino
_____ Not Hispanic /Latino
_____ I (patient or patient's legal guardian) refuse to answer the question.

Race

Please indicate below the line which most accurately identifies your race.

_____ White/Caucasian
_____ Black/ African American
_____ Native American/ Alaska Native
_____ Asian
_____ Native Hawaiian/ Pacific Islander
_____ Hispanic
_____ Other (not covered or cites more than one race)
_____ Unknown
_____ I (patient or patient's legal guardian) refuse to answer the question.

Preferred Language

Please indicate below your preferred language.

_____ English _____ Spanish _____Indian _____Russian _____ Other

Patient Signature:_____ Date: _____