



# South Denver Internal Medicine

*A Concierge Medical Practice*

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<b>Patient Information</b> (please print clearly with full detail)		Today's Date	
Patient's Last Name:		Patients First Name:	
Street Address and Unit #:		City & State	
Patient Cell Phone:		Patient Work Phone:	
Patient Home Phone:		Middle Initial:	
Female <input type="checkbox"/>	Date of Birth:	Age:	Patient's Social Security #:
Male <input type="checkbox"/>			CO Drivers License #
Patient's Occupation:		Patient's Employer and Address:	
Marital Status:		Spouse Name, Address and Phone:	
Married <input type="checkbox"/>	Single <input type="checkbox"/>	Divorced <input type="checkbox"/>	
Parent's Name(s) if Patient is a minor:			
Physician you are here to see today: Charles Miranda, MD		Briefly state the reason for today's visit:	
Who referred you to our practice?		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 Social Security #:	
Primary Insured's DOB:			
Primary Ins. Co Mail Claims to Address (on back of insurance card):		Primary Ins. Co Phone # (claims or benefits):	
Primary Ins. Co Group #:			
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 Social Security #:	
Secondary Insured's DOB:			
Secondary Ins. Co Mail Claims to Address (on back of insurance card):		Primary Ins. Co Phone # (claims or benefits):	
Primary Ins Co Group #:			
<p>RELEASE &amp; 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.</p> <p>CONSENT TO TREAT: I hereby consent to treatment by my physician.</p>			
Patient's Signature (Parent if Patient is a minor child):			Date: