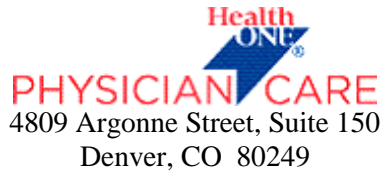


# Aspen Family Medicine at Green Valley Ranch



Today's Date: \_\_\_\_\_

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## PATIENT INFORMATION

Patient Name (last) \_\_\_\_\_ (first) \_\_\_\_\_ (middle) \_\_\_\_\_  
Address \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN \_\_\_\_-\_\_\_\_-\_\_\_\_ Sex (circle) Male Female  
Marital Status (circle) Married Single Divorced Widowed Other \_\_\_\_\_

(Minors ONLY) Parent/Guardian Name (last) \_\_\_\_\_ (first) \_\_\_\_\_  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Email address: \_\_\_\_\_

(For patient satisfaction surveys only)

## CONTACT INFORMATION

Primary Phone # ( ) \_\_\_\_\_ (circle) Home Work Cell /Ok to leave message? Y N  
Alternate Phone # ( ) \_\_\_\_\_ (circle) Home Work Cell/ Ok to leave message? Y N  
Emergency Contact \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Phone # ( ) \_\_\_\_\_

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## INSURANCE INFORMATION (All fields required)

**Primary Insurance** \_\_\_\_\_ Office Visit Copay \$ \_\_\_\_\_  
Policy Holder Name (last) \_\_\_\_\_ (first) \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Address \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Policy Holder SSN \_\_\_\_-\_\_\_\_-\_\_\_\_ Policy Holder DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
Employer Name \_\_\_\_\_ Work Phone \_\_\_\_\_ Occupation \_\_\_\_\_  
**Secondary Insurance** \_\_\_\_\_ Policy Holder Name \_\_\_\_\_  
Relationship to patient \_\_\_\_\_ PolicyHolder SSN \_\_\_\_-\_\_\_\_-\_\_\_\_ DOB \_\_\_\_\_  
Employer Name \_\_\_\_\_ Work Phone \_\_\_\_\_

**\*PLEASE PRESENT INSURANCE CARD AND PHOTO ID TO RECEPTIONIST\***

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## INJURY/ ILLNESS INFORMATION

Briefly state why you are seeing the doctor today \_\_\_\_\_  
Date of injury or first symptom (approximate if necessary) \_\_\_\_\_

## HOW DID YOU HEAR ABOUT US?

\_\_\_\_ Physician (Name) \_\_\_\_\_  
\_\_\_\_ Yellow Pages  
\_\_\_\_ Flyer / Direct Mail  
\_\_\_\_ Internet  
\_\_\_\_ Family or Friend  
\_\_\_\_ Other \_\_\_\_\_

**\*\*OVER\*\***