Internal Medicine
Associates of the Grand Valley
Community HOSPITAL

607 28 1/4 Road
Grand Junction, CO 81506
Phone (970) 243-3300
Fax (970) 243-4464

# New Patient Application

Account # (office only): _____

Date: _____

Doctor: _____ Referred By: _____

Is this a consult for another physician? YES NO Name of Physician: _____

Full Name: _____ DOB: _____

Address: _____

Phone: _____

Primary Insurance: _____ Secondary Insurance: _____

Are you related to an established patient? YES NO Name of relative: _____

How soon to do you need to be seen? _____ Problem: _____

Have you seen any of our physicians before? YES NO Physician Name: _____

Have you seen a physician in the last year? YES NO Physician Name: _____

Current Medication: _____

_____

Your current health problems:

Diabetes Heart Problem Arthritis Breathing Problems

Thyroid Chronic Pain Hypertension High Cholesterol

Chronic Pain: _____

On Going Health Issues: _____

Name of Caller: _____ Phone #: _____ Taken By: _____

Doctors Response YES NO Physician Initials _____

# Pre-Registration Form

| Insured Party Employer | | Employer Plan<br>Y N | Relationship* |
|---|---|---|---|
| **Secondary Insurance Information** | | | |
| Insurance Company Name | Address | City State | Zip |
| Group Name or Number | Insurance ID Number | Phone | |
| Name of the Insured Party (if not the patient) | | Insured Date of Birth | |
| Insured Party Employer | | Employer Plan<br>Y N | Relationship |
| If Workman's Comp Claim- Name, Address and Phone Number of Employer at time of injury | | | |

| ***Race (circle one)*** | | ***Language (circle one)*** | |
|---|---|---|---|
| American Indian/ Alaska Native | Asian | Declined | English |
| Black/ African American | Declined | French | German |
| Native Hawaiian/ Pacific Islander | Other Race | Italian | Japanese |
| Unknown | White | NA | Other |
| ***Ethnicity (circle one)*** | | | |
| Declined | Hispanic or Latino | Asian | Spanish |
| Not Hispanic or Latino | Unknown | Chinese | Unknown |

**Payment for Service**

I agree to pay all fees and charge at the time of treatment unless satisfactory credit or Insurance agreement have been made in advance. I agree to pay all attorneys' fees and costs to the above doctors for any charges incurred to collect any unpaid balance. All past due balance over 30 days will be charged 1.5% interest per month not to exceed 18% annually.

**Medical Release Authorization**

I request that payment of authorized Medicare benefits or other Insurance benefits be made either to me or on my behalf directly to Internal Medicine Associates of the Grand Valley for any service furnished to me by these physicians. I Authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent of my insurer any information needed to determine the benefits payable for related services.

| Patient's or Authorized Person's Signature* | Date: / / | Patient's or Authorized Person's Signature* | Date: / / |
|---|---|---|---|

***All fields/sections marked with an * must be completed.***