



**The
Thayer Group**
for
Women's Care, PC

Phone 303-443-2010 * fax 303-443-7882
1155 Alpine Avenue * Suite 230 • Boulder, CO 80304

PATIENT INFORMATION

Date of Birth _____

Last Name _____ First Name _____ MI _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Work _____ Cell _____
 Phone Number to leave a **personal & or / confidential** messages regarding your medical care or account information _____ (Please read explanation on **reverse side**.)
 Emergency Contact _____ Primary phone _____
 Relationship _____ Secondary phone _____
 Email _____

We Will Not Share Your Email Address, or Participate in 'Spam'. Are you interested in using email to communicate with our office? Yes ___ : No ___. Would you be interested in receiving periodic health updates from our providers if we elect to do so? Yes ___ : No ___. Have you visited our website? Yes ___ No ___.

Please list your Primary Care Provider. (Family Dr., Internist, Nurse Practitioner) if you have one. _____
 Whom may we thank for your referral? _____ How did you hear about us? _____

Insurance Information: Payment is due when services are rendered unless other arrangements have been made in advance. We will file a claim to your insurance carrier if all necessary information is included.

Primary Insurance _____ Effective Date _____
 Name of Insured _____ Relationship _____
 Address, if different _____
 Employer of Insured _____ SSN _____ Date of Birth _____
 Primary Phone _____ Secondary Phone _____

If you have a secondary insurance company, please give us all necessary information.

Is this insurance coverage through a spouse, partner, or parent? If so, complete this section.

Secondary Insurance _____ Effective Date _____
 Name of Insured _____ Relationship _____
 Address, if different _____
 Employer of Insured _____ SSN _____ Date of Birth _____
 Primary Phone _____ Secondary Phone _____

I authorize payment of medical benefits to The Thayer Group for Women's Care for all services provided and permit the release of medical information to my insurance company. I agree to be financially responsible for any charges not covered by insurance. I further agree to hold the Thayer Group for Women's Care and its employees harmless for release of confidential information to the personal phone number designated above.

Signature _____ Witness _____ Date _____