



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

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

Date _____

PATIENT INFORMATION

Last Name _____ First Name _____ MI _____
 I prefer to be called _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Work _____ Cell _____
 Date of Birth _____ Age _____ Social Security Number _____
 Patient's Employer _____
 What type of work do you do? _____
 E-mail _____
 How did you hear about us? _____
 Who may we thank for this referral? _____
 Who is your primary physician/care giver(s)? _____
 Emergency Contact _____ Primary phone _____
 Relationship _____ Secondary Phone _____

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 _____

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

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.

Signature _____