COLORADO CENTER FOR SPINE MEDICINE
4820 Riverbend Rd. 2nd Floor Boulder CO 80301
#303-444-2955 Fax# 303-889-5103

NAME________________________________

ADDRESS: _________________________________ **CITY**____________________________ST______ ZIP________

HOME PHONE (____)________________ **WORK PHONE** (____) ______________ **MOBILE** (____) ______________

DATE OF BIRTH _____________________ **AGE**_____ **SEX M or F** **HEIGHT**_______ **WEIGHT** ________

SOCIAL SECURITY #: __________________________ **EMAIL ADDRESS**_____________________________

WHO REFERRED YOU TO OUR OFFICE? ____

PRIMARY CARE DOCTOR(S): ____

YOUR EMPLOYER: __________________________________ **OCCUPATION:** _______________________

EMERGENCY CONTACT

NAME:____ RELATIONSHIP:______________________________

ADDRESS: _________________________________ CITY __________________________ ST_____ ZIP__________

HOME PHONE (____)________________ MOBILE (____)_____________________

PRIMARY INSURANCE:____ID#__________________________

ADDRESS OF COMPANY:____CITY:__________________________

STATE:_______________ ZIP:_____________TELEPHONE:(_____)___________________

SECONDARY INSURANCE

INSURED'S NAME:____RELATIONSHIP_____________________

NAME OF INSURANCE COMPANY:____ID#____________________________

ADDRESS OF INSURANCE COMPANY:____CITY:__________________________

STATE:_______________ZIP:_____________TELEPHONE:(_____)______________

RELEASE OF MEDICAL INFORMATION TO OTHER CARE PROVIDERS
Often times it may be necessary for CCSM to share medical information with other physicians or health care providers who may be currently involved in your treatment. This allows the doctors to cross reference important medical information to provide you the best care possible. Your doctor can only share your medical records with other care providers when you release him/her to do so. By completing your signature below, you understand all of the above and allow this office to share medical information necessary for your treatment.

SIGNATURE:____ **DATE:**__________________