

2006

WELCOME TO OUR OFFICE

Jane A. Burnham, M.D., Ph.D.

701 E. Hampden, #320
Englewood, CO 80113

Date _____

Patient's Name _____
Last First Middle

Birth date _____ Age _____ Sex _____ Social Security Number _____

Home Phone _____ Work # _____ Cell # _____

Address _____
Street City State Zip

Primary Care Physician _____ Phone _____

Referred by _____ Phone _____

INSURANCE BILLING INFORMATION

Are you seeking treatment for: Work Related Injury _____ Auto Related Injury _____ Date of Injury _____

Primary Insurance _____ Secondary Ins _____

Policyholder's Name _____ Employer _____

CONTACT

Name _____ Relation to Patient _____

Home Phone _____ Work # _____ Cell # _____

Do we have your permission to discuss your medical care with this person? YES ___ NO ___

Any restrictions? _____

Dr. Burnham has my permission to obtain Medical Records from Swedish Medical Center, Porter Memorial Hospital, SkyRidge Medical Center and other local hospitals. YES _____ NO _____.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize payment of medical benefits to Dr. Jane Burnham for these services and all future claims. I authorize the release of any medical information necessary to process this claim and all future claims. I hereby authorize the release of medical records from any hospital or medical facility to ensure continuity of care.

Signature Date

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices.

Signature Date