www.greenwoodentdoctors.com

C. Scott Howe, M.D.
Andrae Lucas, Au.D.

1619 N. Greenwood, Suite 309
Pueblo, Colorado 81003
Phone (719) 544-7115
Fax (719) 544-6242

NEW PATIENT INFORMATION RECORD

(Please Print or Write Legibly)

Date: _______________

Patient Name: ____________________ Birth Date: ____ /____ /______ Soc Sec#: _____ - ____ - _______

Address: ____________________ City: ____________________

State: ____________ Zip Code: __________ Primary Phone: ____________________

Race: __________ Ethnicity: __________ Preferred Language: ____________ Sex: M F (circle one)

Patient's Employer: ____________ Occupation: ____________ Years Employed: ________

Employers Address: ____________________ City: ____________________

State: ____________ Zip Code: __________ Work Phone: ____________________

Emergency Contact: ____________ Relationship: ____________ Phone: ____________

Spouse's Name: ____________ Spouse's Employer: ____________________

Who Is Your Primary Physician: ____________ Referring Physician: ____________

** What is the best number to call: ____________________ Cell or Landline (circle one)

If the Patient is a Minor Or Student

Mother's Name: ____________ Address: ____________ City: ____________

State: ____________ Zip Code: __________ Primary Phone: ____________ Work Phone: ____________

Mother's Employer: ____________ Occupation: ____________ Years Employed: ________

Father's Name: ____________ Address: ____________ City: ____________

State: ____________ Zip Code: __________ Primary Phone: ____________ Work Phone: ____________

Father's Employer: ____________ Occupation: ____________ Years Employed: ________

Insurance Information

Insured's Name (person who insurance is under): ____________________

Insured's D.O.B. ____ /____ /______ Relationship to Patient: ____________________

Employer: ____________________ Phone: ____________

Employers Address: ____________________

City: ____________ State: ____________ Zip Code: ____________

Insurance Name: ____________ I.D. #: ____________ Group #: ____________

In order to control our cost of billing, we request that office visits be paid at the time service is required. We would rather control our billing costs than be forced to raise our fees. You may pay by cash, check, or credit card.

Authorization: I hereby authorize the physician indicated above to furnish information to insurance carriers concerning this illness/accident and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges wether or not covered by insurance, reasonable collections, attorney fees, court costs and post judgement interest.

Responsible party signature: ____________________________________