ROCKY MOUNTAIN SENIOR CARE

Address: 5920 McIntyre Street, Golden, CO 80403 Phone: (720) 434-4876 Fax: (303) 225-4246

NEW PATIENT INFORMATION

CHECK ONE	☐ INDEPENDENT LIVING ☐ ASSISTED LIVING ☐ LONG TERM CARE
PATIENT CONTACT INFORMATION	
NAME	
DATE OF BIRTH / SS#	
ADDRESS	
PHONE NUMBER	
FACILITY	
ROOM NUMBER	
UPDATED ADDRESS FOR MAILED STATEMENTS	
NAME & ADDRESS	
POWER OF ATTORNEY (IF APPLICABLE)	
NAME/RELATION	
ADDRESS	
PHONE NUMBER	
ADDITIONAL CONTACTS	
NAME/RELATION	
PHONE NUMBER	
NAME/RELATION	
PHONE NUMBER	
PATIENT INSURANCE (WE WILL STILL NEED A COPY OF YOUR INSURANCE CARD)	
COMPANY	
POLICY NUMBER	
PHONE NUMBER	
PREVIOUS PRIMARY CARE PROVIDER INFORMATION	
***PLEASE CHANGE THE PRIMARY CARE PROVIDER ON FILE WITH YOUR INSURANCE TO DR. ELANE L. SHIRAR	
NAME	
ADDRESS	
PHONE NUMBER	
FAX NUMBER	
ANNUAL WELLNESS VISIT	
LAST A.W.V. WAS:	☐ OVER A YEAR AGO ☐ LESS THAN ONE YEAR AGO DATE: _____ / _____ / _____

ROCKY MOUNTAIN SENIOR CARE

Address: 5920 McIntyre Street, Golden, CO 80403 Phone: (720) 434-4876 Fax: (303) 225-4246

PATIENT NAME:	DOB:	TODAY'S DATE:
CURRENT MEDICATIONS		
NAME OF MEDICATION (LIST SEPERATLY IF NEEDED)	DOSE	FREQUENCY
ALLERGIES (MEDICATION, ENVIORNMENT, FOODS)		
ALLERGEN	REACTION	
ADDITIONAL CONCERNS		

FORM REVIEWS	
BY INITIALING BELOW, I AM INDICATING THAT I HAVE REVIEWED AND UNDERSTAND THE ATTACHED DOCUMENTS. I UNDERSTAND THAT I CAN CONTACT ROCKY MOUNTAIN SENIOR CARE IF I HAVE ANY QUESTIONS OR WISH TO REVOKE CONSENT FOR SERVICES AT ANY TIME. I UNDERSTAND THAT VERBAL AGREEMENT IS ACCEPTED AND MAY, AT ANY TIME, OVERRIDE THE INDICATIONS BELOW. I UNDERSTAND THAT, UNLESS NOTIFIED OTHERWISE, THESE AUTHORIZATIONS WILL NOT EXPIRE.	
BILLING ARBITRATION AGREEMENT	_____ INITIAL FOR CONSENT _____ INITIAL TO DECLINE
USE OF MEDIA (PHOTOS AND RECORDED VISITS)	_____ INITIAL FOR CONSENT _____ INITIAL TO DECLINE
CHRONIC CARE MANAGEMENT (ANNUAL RENEWAL)	_____ INITIAL FOR CONSENT _____ INITIAL TO DECLINE
BEHAVIORAL HEALTH INTEGRATION	_____ INITIAL FOR CONSENT _____ INITIAL TO DECLINE
HIPAA CONSENT ACKNOWLEDGEMENT	_____ INITIAL FOR CONSENT _____ INITIAL TO DECLINE
NAME OF HIPPA AUTHORIZED INDIVIDUAL/PARTY	
SIGNATURES	
PATIENT NAME	**PRINTED NAME OF RESPONSIBLE PARTY (IF APPLICABLE)**
DATE	**SIGNATURE OF PATIENT/RESPONSIBLE PARTY**