Epstein Neurosurgery Center, LLC
Epstein Neurosurgery Foundation, Inc. 501(c)(3)
Clara Raquel Epstein, MD, FICS
Neurosurgeon/CEO
www.epsteincenter.com
www.epsteinfoundation.org

Administrative Office:
6940 N. 63rd Street
Longmont, CO 80503-8852
Phone: 303.800.9129
Fax: 720.638.0497

PATIENT NAME _____ DATE OF BIRTH ___/_____/_____

PATIENT DEMOGRAPHICS FORM

Patient's First Name _____Middle Name _____ Last Name_____
SSN____-__-_____ Date of Birth ___/__/____ (mm/dd/yyyy) Age____ Sex (circle): ☐Male ☐Female ☐Other
Mailing Address _____ City_____ State_____ Zip Code_____
Home Phone#_____ Work Phone # _____ Cell Phone # _____
Driver's License: State _____ DL#_____DL Expiration Date_____
Social Security#_____ Email Address: _____
Emergency Contact Name _____ Phone #_____
Relationship _____ Cell Phone # _____

Pharmacy Preference _____ Address _____ City_____
State _____ Zip Code _____
Pharmacy Phone # (___) ___-_____ Pharmacy Fax # (___) ___- _____

Referring Provider _____ Phone # (___) ____-_____
Primary Care Provider _____ Phone # (___) ____-_____
If you were referred by a different source than your PCP, please indicate how you found our practice:
Friend/Family Member _____ Internet/Website_____ Other _____

Primary Insurance Company_____ Member ID_____ Group ID_____Expir_____
Secondary Insurance Company_____ Member ID_____ Group ID_____Expir_____
(Please fax copies of front and back of each insurance card to **720.638.0497** as well as Driver's License/State ID)

The following questions are required for "Meaningful Use", a federal mandate established by CMS. These categories were established by CMS, not by our office. These questions will not influence your medical care. These statistics are reported to CMS.

Preferred Language – Please check one:
☐English ☐French ☐German ☐Vietnamese ☐Mandarin ☐Spanish ☐Not Listed_____
Race – Please check as many as apply:
☐Hispanic ☐Asian ☐ Caucasian ☐ Black or African American ☐American Indian or Alaska Native
☐Native American Chinese ☐Filipino ☐Japanese ☐Native Hawaiian ☐Multiracial ☐Pacific Islander
☐Other Undetermined
Ethnicity – Please check one:
☐Hispanic or Latino ☐Non-Hispanic or Non-Latino ☐Other or Undetermined

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PATIENT NAME _____ **DATE OF BIRTH** ___/_____/_____

PATIENT DEMOGRAPHICS FORM (Continued)

Release: I hereby affirm that the information provided is current and accurate and will provide changes to any of the above information in writing as soon as such changes are in effect. I consent to the release of information provided to, or generated by ENC, to my PCP, referring provider, psychologist, attorney, therapist, agency or any other party with a bona fide, pertinent interest, via verbal, written, or fax/email/protected copied disc for communication. A copy or scanned image of my signature shall be as valid as the original.

Patient Signature _____ Date _____

Patient Name (Printed) _____