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:
1245 Pearl Street, Suite#210
Boulder, CO 80302
Phone: 303.800.9129
Fax: 720.638.0497

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 # _____
Drivers License: State _____ DL#_____DL Expiration Date_____

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 Drivers 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 circle one:
English French German Vietnamese Mandarin Spanish Not Listed
Race – Please circle 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 circle one:
Hispanic or Latino Non-Hispanic or Non-Latino Other or Undetermined

Release: I hereby 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 _____

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