

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:

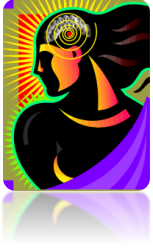
English French German Vietnamese Mandarin Spanish Not Listed _____

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 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) _____