Epstein Neurosurgery Center, LLC
Epstein Neurosurgery Foundation, Inc. 501(c)(3)
Clinical Office By Appointment Only: 109 N. 2nd St., Suite #102, Westcliffe, CO 81252
Phone: 303.800.9129/Fax: 720.638.0497
Clara Raquel Epstein, MD, FICS
Neurosurgeon/CEO
www.epsteincenter.com
www.epsteinfoundation.org

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)

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PATIENT DEMOGRAPHICS FORM (Continued)

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

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) _____