IMMUNOe HEALTH CENTERS
Excellence in Immune Health

Sinus Solutions AT IMMUNOe

HORIZON PEDIATRICS & PRIMARY CARE

Patient Information (Family)

Todays Date: ____ / ____ / ____

List All Children in Family (please print)

Last Name _____ First _____ M.I.____ DOB ____/____/ ____ Sex___ Race/ Ethnicity _____ ☐ Decline
Last Name _____ First _____ M.I.____ DOB ____/____/ ____ Sex___ Race/ Ethnicity _____ ☐ Decline
Last Name _____ First _____ M.I.____ DOB ____/____/ ____ Sex___ Race/ Ethnicity _____ ☐ Decline
Last Name _____ First _____ M.I.____ DOB ____/____/ ____ Sex___ Race/ Ethnicity _____ ☐ Decline

Preferred Method of Contact: ☐ Voice Call ☐ Text Message ☐ Email

Preferred Language: _____

Emergency Contact: _____ Phone: _____

Parent / Guardian Information (please print)

☐ Mother ☐ Father ☐ Other: _____

Name: _____

Address: _____

City, State, Zip: _____

Social Security # : _____

DOB : _____ / _____ / _____

Phone: (H) _____ - _____ - _____
(C) _____ - _____ - _____
(W _____ - _____ - _____ ext. ___

Employer: _____

Address: _____

City, State, Zip: _____

Email: _____

☐ Mother ☐ Father ☐ Other:

Name: _____

Address: _____

City, State, Zip: _____

Social Security # : _____

DOB : _____ / _____ / _____

Phone: (H) _____ - _____ - _____
(C) _____ - _____ - _____
(W _____ - _____ - _____ ext. ___

Employer: _____

Address: _____

City, State, Zip: _____

Email: _____

Are there any court orders concerning medical decisions for your child(ren) ? ☐ No ☐ Yes (If yes, please provide a copy for chart)

Insurance Information (please print)

Primary Physician name: _____ Do you have a Pharmacy Preference? ☐ No ☐ Yes

Pharmacy Name: _____ Street Name: _____ Phone: ____ - ____ - _____

Primary Health Insurance

Company: _____

Policy Holder's Name: _____

Policy Holder's DOB ____ / ____ / _____

Relation To Patient : ☐ Father ☐ Mother

Other: _____

Policy Holder's Soc. Sec. # : _____ - _____ - _____

Group #: _____ ID#: _____

Employer: _____

Effective Date _____ / _____ / _____

Secondary Health Insurance

Company: _____

Policy Holder's Name: _____

Policy Holder's DOB ____ / ____ / _____

Relation To Patient : ☐ Father ☐ Mother

Other: _____

Policy Holder's Soc. Sec. # : _____ - _____ - _____

Group #: _____ ID#: _____

Employer: _____

Effective Date _____ / _____ / _____

I authorize payment of medical benefits to IMMUNOe Health Centers for today's service and all future services.

I authorize the release of any medical information necessary to process today's claim and any future claims.

Printed Name _____ Signature _____ Date _____

IMMUNOe HEALTH CENTERS
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HORIZON PEDIATRICS & PRIMARY CARE

Patient Information (Adult)

Todays Date: ____ / ____ / ____

Patient Information (please print)

Last Name: _____ First : _____

M.I. _____

DOB : _____ / _____ / _____ SSN: _____ - _____ - _____ Sex: _____ Marital Status : _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: ____ - ____ - _____ Work Phone: ____ - ____ - _____ Ext. _____ Cell Phone: ____ - ____ - _____

Email: _____ Employer Name: _____ ☐ Decline

Race / Ethnicity: _____ ☐ Decline Preferred Language: _____

Preferred Method of Contact: ☐ Voice Call ☐ Text Message ☐ Email

Next of Kin Information (Name of nearest relative or close friend not living with you, in case of emergency):

Name: _____ Home Phone: ____ - ____ - _____ Cell Phone: ____ - ____ - _____

Physicians Involved In Your Treatment (please print)

Physician Name: _____ Specialty: _____ Phone: ____ - ____ - _____

Physician Name: _____ Specialty: _____ Phone: ____ - ____ - _____

Primary Physician name: _____ Do you have a Pharmacy Preference? ☐ No ☐ Yes

Pharmacy Name: _____ Street Name: _____ Phone: ____ - ____ - _____

Insurance Information (please print)

Primary Health Insurance

Company: _____

Policy Holder's Name: _____

Policy Holder's DOB ____ / ____ / _____

Relation To Patient : ☐ Father ☐ Mother

Other: _____

Policy Holder's Soc. Sec. # : _____ - _____ -_____

Group #: _____ ID#: _____

Employer: _____

Effective Date _____ / _____ / _____

Secondary Health Insurance

Company: _____

Policy Holder's Name: _____

Policy Holder's DOB ____ / ____ / _____

Relation To Patient : ☐ Father ☐ Mother

Other: _____

Policy Holder's Soc. Sec. # : _____ - _____ -_____

Group #: _____ ID#: _____

Employer: _____

Effective Date _____ / _____ / _____

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I authorize the release of any medical information necessary to process today's claim and any future claims.

Printed Name _____ Signature _____ Date _____

CENTENNIAL
6801 South Yosemite Street
Centennial, CO 80112
F: 303.770.1449

THORNTON: ALLERGY & ASTHMA
3240 East 104th Avenue
Thornton, CO 80233
F: 303.452.4392

THORNTON: PEDIATRICS
3260 East 104th Avenue
Thornton, CO 80233
F: 720.929.8444

GREEN VALLEY RANCH
18620 Green Valley Ranch Blvd.
Suite #101 Denver, CO 80249
F: 303.574.1800

SMOKY HILL
15470 E Smoky Hill Rd.
Aurora, CO
F: 720.870.2517

LONGMONT
1551 Professional Lane Ste. 280
Longmont, CO 80501
F: 303.776.0848