Town Clinic of Crested Butte, PLLC

P.O. Box 1546
Crested Butte, CO 81224

214 6th Street, Suite 1
(970) 349-6749

Eric Thorson, M.D.

Patient Registration Form

If you have a hyphenated last name or a different last name than some members of your family, or if you occasionally go by different variations of your name, PLEASE SELECT A NAME WE MAY USE CONSISTENTLY FOR YOU IN OUR OFFICE, ON YOUR ACCOUNT AND WHEN ADDRESSING YOU. Otherwise we often end up making duplicate accounts based on differing names used by the same person. *Thank you for your help!!*

~ please print ~

Information for patient being seen today:

Last Name:_____ First Name:_____ M.I.:_____

Mailing Address:_____ City:_____ State:_____ ZIP:_____

Social Security Number:_____ Date of Birth:_____

Sex: M F Marital Status:_____ Email:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Billing Information:

If patient is child of separated or divorced parents, **we bill the parent bringing the child in to be seen**.

Bill this patient's account to: □ *same as above*

Last Name:_____ First Name:_____ M.I.:_____

Mailing Address:_____ City:_____ State:_____ ZIP:_____

Social Security Number:_____ Date of Birth:_____

Sex: M F Marital Status:_____ Email:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Relationship to the person being seen today:_____

Employer Name:_____ Phone:_____

Employer Address:_____ City:_____ ZIP:_____

We need a copy of your insurance card at each visit.

Full name on insurance policy:_____ Date of Birth:_____

This person's relationship to the patient:_____

Employer of person whose insurance policy applies:_____

If information of insurance policy holder is different than the patient's, please complete the following:

Mailing Address:_____ City:_____ State:_____ ZIP:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Once completed, please return to reception desk. Thank you!!