ECCO MEDICAL
ENDOVASCULAR CONSULTANTS OF COLORADO

8080 Park Meadows Drive, Suite 150
Lone Tree, CO 80124
720-668-8818 office | 877-229-5440 fax

PATIENT INFORMATION

Name (last, first, middle): _____

DOB: _____/_____/_____ Social Security Number: _____

Street Address: _____

City/State/Zip: _____

Gender: Male / Female Marital Status: Single / Married / Widowed / Divorced / Separated

Occupation: _____ Work Status: Employed / Unemployed / Retired / Disabled

Race (please check one)

- ☐ Not specified / Other
- ☐ Native American or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hawaiian Native or Other Pacific Islander
- ☐ White

Ethnicity (please check one)

- ☐ Not specified / Other
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Preferred Language: _____

Communication Preferences:
ECCO Medical contacts patients for a variety of reasons, including appointment reminders and imaging and procedural calls. Please let us know how you prefer us to communicate with you.

Primary Phone Number: _____

Primary Phone Type: ☐ Cell Phone ☐ Home Phone ☐ Work Phone

Primary Phone Requests: ☐ NO VOICEMAIL ☐ NO TEXT

Seconday Phone Number: _____

Seconday Phone Type: ☐ Cell Phone ☐ Home Phone ☐ Work Phone

Secondary Phone Requests: ☐ NO REMINDER CALLS ☐ NO VOICEMAIL ☐ NO TEXT

Email Address: _____

Your email will only be used to communicate with you regarding your healthcare at ECCO Medical and never sold or shared with any third party. You will be invited to enroll in our Patient Portal where you can view and edit upcoming and past appointments, request health history and communicate with your care team. You may opt out of the Patient Portal at any time.

**Please bring a copy of your driver's license and health insurance card, if applicable, with you to every visit.*

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Patient Emergency Contacts

1. Name (First, Last) _____ Relationship: _____

Phone Number: _____ home / cell

☐ This contact is authorized for ECCO to release PHI ☐ This contact has Power of Attorney

2. Name (First, Last) _____ Relationship: _____

Phone Number: _____ home / cell

☐ This contact is authorized for ECCO to release PHI ☐ This contact has Power of Attorney

3. Name (First, Last) _____ Relationship: _____

Phone Number: _____ home / cell

☐ This contact is authorized for ECCO to release PHI ☐ This contact has Power of Attorney

Patient Care Team

Primary Care Physician: _____ Phone Number: _____

Medical Office: _____ Fax Number: _____

Referring Physician: _____ Phone Number: _____

Medical Office: _____ Fax Number: _____

Patient Consent to Release Protected Health Information

ECCO Medical is authorized to release my Personal Health Information to those contacts specified above in addition to any other physicians in my care team or as allowed by current HIPAA rules and regulations.

This authorization is in force until:
☐ It is cancelled in writing ☐ Other: _____

_____ _____
Patient Name (Please Print) Date

_____ _____
Patient/Guardian Signature Relationship to Patien

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Insurance Information

PLEASE HAVE YOUR PHOTO ID & INSURANCE CARDS AT EVERY VISIT. ALL COPAYS ARE DUE AT THE TIME OF THE SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

Primary Insurance

Insurance Carrier:	Effective Date:
Member ID:	
Group:	
Policy Holder Name:	Policy Holder DOB:
Policy Holder SSN:	Policy Holder Employer:

Secondary Insurance

Insurance Carrier:	Effective Date:
Member ID:	
Group:	
Policy Holder Name:	Policy Holder DOB:
Policy Holder SSN:	Policy Holder Employer:

Tertiary Insurance

Insurance Carrier:	Effective Date:
Member ID:	
Group:	
Policy Holder Name:	Policy Holder DOB:
Policy Holder SSN:	Policy Holder Employer:

_____ _____
Patient Name (Please Print) Date

_____ _____
Patient/Guardian Signature Relationship to Patient

**Please bring a copy of your driver's license and health insurance card, if applicable, with you to every visit.*