UCCS HealthCircle
UNIVERSITY OF COLORADO
COLORADO SPRINGS

UCCS HealthCircle
Primary Care Clinic and Peak Nutrition Clinic
4863 N. Nevada Ave. Suite 250
Colorado Springs, CO 80918

Patient Information Sheet

Today's Date:_____

Patient Full Name: _____ **Patient Date of Birth**: _____

Preferred Name: _____ **Social Security Number:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Email Address: _____ **Language preference**: _____

Preferred Pharmacy: _____ Rx Location: _____

(_____) _____ Home Cell Work Okay to leave detailed message? Yes / No

(_____) _____ Home Cell Work Okay to leave detailed message? Yes / No

(_____) _____ Home Cell Work Okay to leave detailed message? Yes / No

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Please circle all that apply: American Indian/Alaska Native Native Hawaiian/Other Pacific Islander

Black/African American White Hispanic/Latino Asian Other _____

Emergency Contact Name: _____Phone number: _____

Relationship to Patient: _____Mailing Address: _____

☐Self-Pay (No Insurance) – Please Check Box

Primary Insurance Company: _____ Policy/Member ID#: _____

Group#:_____ Policy Holder's DOB: _____

Policy Holder's SSN: _____ Contact Phone Number: (____) _____

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's Mailing Address: _____

Secondary Insurance Company: _____ Policy/Member ID#: _____

Group#:_____ Policy Holder's DOB: _____

Policy Holder's SSN: _____ Contact Phone Number: (____) _____

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's Mailing Address: _____