Guarantor Information

(Person responsible for payment)

Guarantor's Last Name:	First Name:	Birth Date:	Social Security No:
Complete Mailing Address:	**Phone Number:**	**Patients Relationship to Guarantor:** *Self /Spouse /Child / Other: ___________*	

Medical Insurance Information

(Please make sure to give us a copy of your card)

Primary Insurance Company:	Policy Number:	Group ID:	
Policy Holder's Last Name:	**First Name:**	**Birth Date:**	**Social Security No:**
Complete Mailing Address:	**Phone Number:**	**Patients Relationship to Policy Holder:** *Self /Spouse /Child / Other: ___________*	
Secondary Insurance Company:	**Policy Number:**	**Group ID:**	
Policy Holder's Last Name:	**First Name:**	**Birth Date:**	**Social Security No:**
Complete Mailing Address:	**Phone Number:**	**Patients Relationship to Policy Holder:** *Self /Spouse /Child / Other: ___________*	

Dental Insurance Information

(Please make sure to give us a copy of your card)

Primary Insurance Company:	Policy Number:	Group ID:	
Policy Holder's Last Name:	**First Name:**	**Birth Date:**	**Social Security No:**
Complete Mailing Address:	**Phone Number:**	**Patients Relationship to Policy Holder:** *Self /Spouse /Child / Other: ___________*	
Secondary Insurance Company:	**Policy Number:**	**Group ID:**	
Policy Holder's Last Name:	**First Name:**	**Birth Date:**	**Social Security No:**
Complete Mailing Address:	**Phone Number:**	**Patients Relationship to Policy Holder:** *Self /Spouse /Child / Other: ___________*	

To help keep costs low to ALL patients your household and income data is used for confidential grant and reporting purposes. This information can also be used to reduce your Co-Pay, if you qualify. If you would like to apply for a reduced Co-Pay please speak with one of our Certified Application Counselors.

NUMBER OF PEOPLE IN HOUSEHOLD (Include self)	Average Monthly Income

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance owed, not paid by my insurance. I also authorize Uncompahgre Medical Center and my Insurance to release any information required to process my claims.

____ ________________

Signature ***Today's Date***