



**Anderson Medical Center**

4743 Arapahoe Avenue, Suite 102  
Boulder, CO 80303

www.alpinesurgical.net  
Phone 303.449.3642 Fax 303.440.7298

Today's Date: \_\_\_\_\_

PATIENTS FULL NAME (please print): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**GUARANTOR INFORMATION:** Person who is responsible for payment.

Name: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Employer Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**Please complete the section below if you are over 18 and wish to allow a friend, spouse, parent, or other family member to discuss medical and/or billing information with our office.**

**Authorization to Discuss Medical and Billing Information**

I, \_\_\_\_\_, hereby authorize Alpine Surgical to discuss my medical and billing information with the following listed persons.

First and Last name of authorized person:

Relationship: (i.e.: mother, son, spouse, friend)

1: \_\_\_\_\_

1: \_\_\_\_\_

2: \_\_\_\_\_

2: \_\_\_\_\_

3: \_\_\_\_\_

3: \_\_\_\_\_

4: \_\_\_\_\_

4: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_