

BEN LEE, M.D., LLC  
3701 S. CLARKSON ST., STE. 200  
ENGLEWOOD, CO 80113  
303-783-9997  
Fax: 303-761-8959

**PATIENT INFORMATION**

Name \_\_\_\_\_ SS / HC / Patient ID # \_\_\_\_\_  
Last First Middle In  
Address \_\_\_\_\_ Email \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Primary Phone \_\_\_\_\_ Secondary phone \_\_\_\_\_  
Gender M F Age \_\_\_\_\_ Birth date \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Widow \_\_\_\_\_  
Minor \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_  
Patient Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer/School Address \_\_\_\_\_ Phone \_\_\_\_\_  
Whom may we thank for the referral? \_\_\_\_\_  
Emergency contact \_\_\_\_\_ Phone \_\_\_\_\_

**Insurance Information – If applicable**

Person responsible for account \_\_\_\_\_  
Last First Middle Initial  
Relation to patient \_\_\_\_\_ Birth date \_\_\_\_\_ Social Sec. # \_\_\_\_\_  
Address (if different than patient) \_\_\_\_\_ Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Responsible person employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_  
Subscriber ID # \_\_\_\_\_ Group # \_\_\_\_\_

**Additional Insurance**

Secondary Insurance \_\_\_\_\_ Phone \_\_\_\_\_  
Subscriber ID # \_\_\_\_\_ Group # \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependants have insurance coverage with \_\_\_\_\_. I assign directly to Dr. Ben Lee all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will and when my current treatment plan is completed or one year from the date signed below.

Signature of patient/guardian \_\_\_\_\_ Date \_\_\_\_\_

Print name \_\_\_\_\_ Relation to patient \_\_\_\_\_

**Medical History**  
**( Please Print )**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_  
Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

PLEASE LIST PRIOR SURGERIES AND APPROXIMATE DATES

Date of Surgery	Surgery	Surgeon

Did you experience any complications with any surgeries?	Yes	No
If so, please explain _____		
Do you bruise easily?	Yes	No
Do you use aspirin, ibuprofen or other anti-inflammatory products frequently?	Yes	No
When did you last use this type of product? _____		
Do you use diet pills, either over the counter products or prescription products?	Yes	No

**Please list any allergies that you have:**

Medication	Reaction

Are you allergic or sensitive to soy bean based or paba products?	Yes	No
Are you presently under a physicians care?	Yes	No
If yes, what for _____ Physician _____		
Do you have any chronic nose or sinus complaints?	Yes	No
Please describe _____		
Do you have frequent headaches?	Yes	No
Please describe _____		
Do you wear contacts?	Yes	No

**Please list all medications that you are currently on and the reason for taking them:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**This section is for female patients only**

Date of last menstrual period \_\_\_\_\_ Do you use birth control pills?    Yes    No  
Have you ever been pregnant? Yes No    Any complications? \_\_\_\_\_  
Did you breast feed your children? Yes No    If yes, how long? \_\_\_\_\_

**The information on these pages are true and have been provided in full. I agree to keep Dr. Ben Lee informed of all information pertaining to my medical history.**

Patient signature \_\_\_\_\_ Date \_\_\_\_\_  
Please Print \_\_\_\_\_

Consent to Use and Disclose of Health Information  
For Treatment, Payment or Healthcare Operations

I, \_\_\_\_\_, understand that as part of my health care, Dr. Ben Lee originates and maintains paper and or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

A basis for planning my care and treatment.

A means of communication among the many health professionals who contribute to my care.

A source of information for applying my diagnosis and surgical information to my bill.

A means by which a third party payer can verify that services billed were actually provided.

A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professions.

I understand and have been provided with a Notice of Information Practices that provide a more complete description of information uses and disclosures.

I understand that I have the right to review the notice prior to signing this consent.

I understand Dr. Ben Lee reserves the right to change it's notices and practices.

I understand that I have the right request restrictions as to how my health information may be used or disclosed to carry out treatments, payments or healthcare operations and that Dr. Ben Lee is not required to agree to the restrictions requested.

I understand that I may revoke this consent in writing, except to the extent that Dr. Ben Lee has already taken action in reliance thereon.

I wish to have the following restrictions to use or disclose my health information:

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I fully understand and accept/decline the terms of this consent.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
Please Print \_\_\_\_\_