



FREMONT COUNTY DEPARTMENT OF PUBLIC HEALTH & ENVIRONMENT

Phone: 719-276-7450 | 201 N. 6th Street, Cañon City, CO 81212 | Fax: 719-276-7451



Patient Registration Form

Patient Information

Patient's Name: (Last) (First) (MI)

Address: City, State, Zip:

Phone: E-Mail Address:

DOB: Sex: Female Male Other

Preferred Language: English Spanish Indian: Hindi, etc. Japanese Chinese Korean French German Russian Other

Race: American Indian/Alaska Native Asian Native Hawaiian/Pacific Islander Black/African American White Hispanic Other Declined

Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined

Primary Care Physician: Physician Phone:

Emergency Contact

*Emergency Contact Name: (Last) (First)

Phone number: Relationship to patient: Guardian

*Please tell us who to contact in case of emergency (parent or guardian if under age 18): An emergency would be severe bleeding, unconsciousness, or an accident or condition requiring ambulance transport or hospitalization.

Insurance Information

We recommend that you check with your health plan prior to receiving any medical services to assess your benefits and eligibility for coverage.

No Insurance Medicaid Medicare Private Insurance Name:

Policy #: Group #:

(only if different than patient) Subscriber Name: Phone:

Address, City, State, Zip: SSN: - -

By signing below, I hereby authorize Fremont County Department of Public Health & Environment to disclose any portion of the patient's medical record necessary to my insurance for reimbursement of services and request that payment of authorized benefits be made to Fremont County Department of Public Health & Environment.

FINANCIAL/WAIVER POLICY

It is my responsibility to understand my insurance benefits and plan coverage. This assignment will remain in effect until revoked by me in writing. By signing this document (below), I understand that if claims are denied due to eligibility status, missing or invalid medical group information or invalid network services, I will assume full responsibility for all charges incurred by me or my dependents. Additionally, I will be held financially responsible for any non-covered benefits, deductibles or any co-payments for services, which are provided by Fremont County Department of Public Health & Environment.

Signature of Patient/Parent/Legal Guardian

Date