FREMONT COUNTY DEPARTMENT OF
PUBLIC HEALTH & ENVIRONMENT
201 N. 6TH STREET
CAÑON CITY, CO 81212
PHONE: 719-276-7450 FAX: 719-276-7451

PATIENT REGISTRATION – PLEASE FILL OUT ALL QUESTIONS ON THIS FORM

Last Name: ________________________ **First Name:** ________________ **Date of Birth:** ______________ **M:** ___ **F:** ____

If the patient is a minor, please list name of parent or legal guardian here: _______________________________________

Address: __________________________ **City:** _______________ **State:** _______ **Zip:** ________ **Phone:** _____________

Ethnicity: (circle one) - Caucasian - Hispanic - Non-Hispanic - African American - Native American - Other __________

Preferred Language: - (Circle one) - English - Spanish - Other ________________

Primary Care Physician: ____ **Physician Phone:** ________________________

*__Emergency Contact:__ ___________________________________ **Phone:** ____
*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.

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

INSURANCE/PAYMENT INFORMATION-

No Insurance (NI) [ ] Alaska Native (AN) [ ] American Indian (AI) [ ]

Medicare #: ____ **Medicaid #:** ____________________________________

Private Insurance Name: ____ **Policy #:** __________________________

Member ID #: ____ **Group/Plan #:** __________________________________

Subscriber's Name: ____ **Subscriber's DOB:** ________________________

By signing below, I hereby authorized 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 Printed Name/Relationship Date