

ARAPAHOE PEAK HEALTH CENTER

Registration Form

Patient Information

Today's Date _____

Patient Name _____

Last

First (Legal)

Initials/ Nickname

Home Phone () _____ Work Phone () _____ Fax () _____

Permanent Mailing Address _____

City _____ State _____ Zip _____

SS# _____ - _____ - _____ Sex M F Birth Date _____ / _____ / _____ Age _____

Patient's Employer _____ Address _____

City _____ State _____ Zip _____

Occupation _____ Retired? Y N

Marital Status S M W D Spouse's Full Name _____

Spouse's Employer _____ Bus. Phone _____ Occupation _____

In Case of Emergency (Relative not living with you) _____

Relationship _____ Phone _____

How were you referred to us? _____

INSURANCE

Primary Company: _____

Address _____ City _____

State _____ Zip _____ Phone _____

Policy # _____ Group # _____

Name of the policyholder _____

Relationship _____ Address _____

City _____ State _____ Zip _____ Phone _____

SS# _____ - _____ - _____ Sex M F Birth Date _____ / _____ / _____

Employer _____ Occupation _____

Secondary Company: _____

Address _____ City _____

State _____ Zip _____ Phone _____

Policy # _____ Group # _____

Name of the policyholder _____

Relationship _____ Address _____

City _____ State _____ Zip _____ Phone _____

SS# _____ - _____ - _____ Sex M F Birth Date _____ / _____ / _____

Employer _____ Occupation _____

Is this visit covered by Workman's Compensation? Y N If yes, please provide the following:

Name of the Workman's Compensation Carrier _____

Address _____ City _____

State _____ Zip _____ Phone _____

Claim # _____ Case Worker's Name _____

Case Worker's Phone Number _____

Assignment of Benefits:

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered. I authorize release of all medical information necessary to process my insurance claims or that is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled to the above named physician or clinic. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered valid as the original.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Patient _____ Date _____

Responsible Party _____ Date _____