THE CHILDREN'S HOSPITAL PREREGISTRATION WORKSHEET
(PLEASE COMPLETE ENTIRE FORM – PRINT OR TYPE)

Today's Date: _____
Appointment / Admission Date _____
Clinic: _____
Provider: _____

For Hospital Use Only
Downtime
Medical Record #: _____
Account #: _____

PATIENT INFORMATION

Has patient been seen before at Children's Hospital? (yes/no) Date: _____
Patient's full **Legal** Name: (last, first, middle): _____
Date of Birth _____ Sex _____ Language _____ Social Security #: _____
Street Address: _____ City _____ State _____ Zip _____
Home Phone: (___) _____ Has patient been seen here under a **different** name? (yes/no)
If yes, give full name: _____
Any known allergies _____ Religion _____ Birth State _____

PHYSICIAN INFORMATION

Patient's Primary Care Physician (physician who provides well-child care): _____
Address, City, State, Zip: _____ Phone: _____
Who referred you to our hospital/clinic? _____ Reason for visit: _____

PARENT/LEGAL GUARDIAN #1

Relationship: _____
Full **Legal** Name: (last, first, middle): _____
Date of Birth: _____ Social Security #: _____ Sex: _____
Address (if different from patient): _____ Phone #: (___) _____
Place of Employment: _____ Phone #: (___) _____
Street Address: _____ City _____ State _____ Zip _____
Employment Status: Full time ☐ Part time ☐ Unemployed ☐ Occupation: _____

PARENT/LEGAL GUARDIAN #2

Relationship: _____
Full **Legal** Name: (last, first, middle): _____
Date of Birth: _____ Social Security #: _____ Sex: _____
Address (if different from patient): _____ Phone #: (___) _____
Place of Employment: _____ Phone #: (___) _____
Street Address: _____ City _____ State _____ Zip _____
Employment Status: Full time ☐ Part time ☐ Unemployed ☐ Occupation: _____

PLEASE FILL OUT REVERSE SIDE

EMERGENCY CONTACT AND OR FOSTER PARENT

Name (Last, First, Middle): _____

Relationship: _____ Phone #: (___) _____

INSURANCE COVERAGE

PLEASE PRESENT YOUR INSURANCE/MEDICAID CARD AT TIME OF PATIENT'S APPOINTMENT.
This information must be complete. Incomplete information will result in billing the guardian directly.

PRIMARY INSURANCE (First Insurance to be billed):

Name of Insurance Company: _____ Phone #: (___) _____

Street Address: _____ City _____ State _____ Zip _____

Name of insured (person who carries coverage): _____

Subscriber or Social Security #: _____ Policy or Group #: _____

Authorization or Referral #: _____ # of Auth. Visits: ___ Expiration Date: _____

SECONDARY INSURANCE (Second Insurance to be billed):

Name of Insurance Company: _____ Phone #: (___) _____

Street Address: _____ City _____ State _____ Zip _____

Name of insured (person who carries coverage): _____

Subscriber or Social Security #: _____ Policy or Group #: _____

Authorization or Referral #: _____ # of Auth. Visits: ___ Expiration Date: _____

MEDICAID OR MEDICARE PATIENT:

What is the patient's Medicaid State I.D. #: _____ County: _____

Colorado Access ☐ Other Please List _____

OTHER

School System ☐ HCP ☐ CCS ☐ CRDP ☐ IHS ☐ Scottish Rite ☐ Grant ☐

Name of Agency: _____ Phone #: (___) _____

Street Address: _____ City: _____ State: _____ Zip: _____

IF SELF PAY: (if none of the above apply) Please contact the Financial Counselor's Office at 861-6991.