Patient Registration
Please Print Clearly

Today's Date_____

Patient Name: (This section refers to Patient Only)

Name: _____

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

Home Phone: _____ Work Phone: _____ Employer: _____

Date of Birth: _____ Age: _____ Sex: _____ Soc. Sec. #: _____

Responsible Party: (Person who should receive bill)

Name: _____ Relationship to Patient: Self Spouse Parent Other

Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Auto Injury Claim # _____ Date of Accident: _____

Work Comp Claim #_____ Date of Accident: _____

Referred by: _____

Insurance: (Please complete thoroughly. We will need a copy of your insurance card.)

Primary Insurance: _____ Secondary Insurance: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Phone: _____ Phone: _____

Primary Insured Person: _____ Primary Insured Person: _____

ID/Policy #: _____ ID/Policy #: _____

Group #: _____ Group #: _____

Notify in Emergency: (Not living with you)

Name: _____ Cell #: _____Home #: _____

Please sign: I authorize payment of medical benefits from my insurance to Colorado HealthQuest and the release of any medical information relating to all claims for benefits submitted on behalf of myself and/or dependents. I understand that I am responsible for all charges including those not covered by insurance. Any money paid to you by your insurance company for services rendered and billed by Colorado HealthQuest or any of its associates shall be paid to Colorado HealthQuest immediately upon receipt. I understand that failure to do so is illegal.

Signature of Patient/Insured: _____