Family Medicine
personalized care

PATIENT REGISTRATION FORM

501 Anglers Drive, Ste 201
Steamboat Springs, CO 80487
steamboatfamilydoc.com
970-871-1323 / 970-871-9177

PATIENT INFORMATION

Last Name_____ First Name _____ M____ Birth Date ____/____/_____

Primary Mailing Address _____

City _____ State _____ ZIP _____

Secondary Mailing Address (if applicable)_____

City _____ State _____ ZIP _____

Phone (____) _____ Cell Phone (____) _____ Work Phone (___)_____

Email _____

Marital Status _____ Gender _____ SS# _____-_____-_____

Optional: Race _____ Ethnicity _____ Language _____

Preferred method of contact (circle one): Phone E-mail Letter

Employer _____ Phone (_____) _____

Spouse/Guardian Name _____ SS# _____-_____-_____Birth Date ___/___/_____

Emergency Contact _____ Phone (_____) _____

Emergency Contact _____ Phone (_____) _____

Responsible person for account if different than patient

Name _____ SS# _____-____-_____ Birth Date ___/___/_____

Address _____ City _____ State ___ ZIP _____ Phone (____) _____

INSURANCE INFORMATION

Insurance #1 _____

PRIMARY CARDHOLDER NAME _____ DATE OF BIRTH ___/___/_____

Relationship to Patient _____ INS ID# _____ Group # _____

Insurance #2 _____

PRIMARY CARDHOLDER NAME _____ DATE OF BIRTH ___/___/_____

Relationship to Patient _____ INS ID# _____ Group # _____

PLEASE REVIEW THE ATTACHED POLICIES, THEN COMPLETE THE SIGNATURES PAGE IN REGARDS TO FINANCIAL, PRIVACY PRACTICES AND COMMUNICATION AGREEMENTS.

WE ARE HAPPY TO PROVIDE ADDITIONAL COPIES FOR YOUR RECORDS.

Revised 01/2018