

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

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

PATIENT INFORMATION

Has patient been seen before at The Children's Hospital? yes no Date: _____
Patient's full legal name: (last, first, middle) _____
Date of Birth: ____/____/____ Social Security Number: ____-____-____
Street Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Birth State: _____
Gender: male female Language: English Spanish Other _____
We are asking you questions about your race, ethnicity, and your primary language because we are required to by law since we receive federal funding/assistance. This information will not be used to determine your eligibility for receiving services.
Race: American Indian or Alaskan Native Asian Black or African American
 Native Hawaiian or Other Pacific Islander White More than one race
 Refused/Not Reported
Ethnicity: Hispanic or Latino Not Hispanic or Latino
Has patient been seen here under a **different** name? yes no
If yes, give full name: _____

PHYSICIAN INFORMATION

Who do you take your child to when they are ill or for a regular check up? _____
Physician's Address: _____ City: _____ State: _____ Zip: _____
Physician's Phone: _____ Reason for today's visit: _____
Who referred you to our hospital/clinic? _____

PARENT/LEGAL GUARDIAN #1

Relationship to patient: _____ Gender: Male Female
Full legal name: (last, first, middle) _____
Date of Birth: ____/____/____ Social Security Number: ____-____-____
Address (if different from patient) _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Place of Employment: _____ Phone: _____
Employer's Address _____ City: _____ State: _____ Zip: _____
Employment status: full time part time unemployed Occupation: _____

PARENT/LEGAL GUARDIAN #2

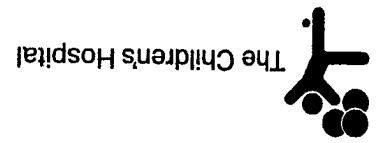
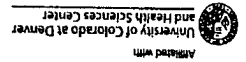
Relationship to patient: _____ Gender: Male Female
Full legal name: (last, first, middle) _____
Date of Birth: ____/____/____ Social Security Number: ____-____-____
Address (if different from patient) _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Place of Employment: _____ Phone: _____
Employer's Address _____ City: _____ State: _____ Zip: _____
Employment status: full time part time unemployed Occupation: _____

Please fill out reverse side



The Children's Hospital

Affiliated with
University of Colorado at Denver
and Health Sciences Center



FOSTER PARENT

Full legal name: (last, first, middle) _____
Phone # _____
Agency: _____
County: _____

EMERGENCY CONTACT INFORMATION

Name: (last, first, middle) _____
Relationship to patient: _____
Phone: _____

INSURANCE INFORMATION

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

Primary Insurance (first insurance to be billed):

Name of insurance company: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Phone: _____
Name of insured (person who carries coverage): _____
Subscriber ID Number: _____
Policy or Group # _____
Relationship to patient: _____
Exp. Date: _____
of visits authorized _____

Secondary Insurance (second insurance to be billed):

Name of insurance company: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Phone: _____
Name of insured (person who carries coverage): _____
Subscriber ID Number: _____
Policy or Group # _____
Relationship to patient: _____
Exp. Date: _____
of visits authorized _____

Medicaid

Patient's state ID # _____
County: _____
 Colorado Access
 Other: (please specify): _____

Other:

School System
 HCP
 CCS
 CRDP
 IHS
 Scottish Rite
 Grant

Name of agency: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

Self Pay: (if none of the above apply)

Please contact the Financial Counselor's Office at 720-777-6408