

Med Peds Clinic of Fort Collins, LLC
4674 Snow Mesa Drive, Ste 120
Fort Collins, CO 80528

Adult Registration Sheet

Patient's Name _____ Phone# _____
Last First Middle
Address _____
City _____ State _____ Zip _____
Social Security # _____ Sex M F Date of Birth _____
 Single Married Widowed Separated Divorced
In case of emergency who should be notified? _____ Phone# _____
Whom may we thank for referring you? _____
Patient Employed by _____ Occupation _____
Business Address _____ Business Phone# _____

Guarantor (Person to whom we should send bills or other correspondence)

Name _____
Date of Birth _____ Social Security # _____
Address (if different than patient) _____
City _____ State _____ Zip _____
Phone # _____

Primary Insured (Insurance Subscriber)

Name of Insured _____
Date of Birth _____ Social Security # _____
Address (if different than patient) _____
City _____ State _____ Zip _____
Phone # _____

Protected Health Information Waiver

Please list the names of any individuals to whom you give the staff at Med Peds Clinic permission to discuss protected health information with.

Assignment of Benefits/Release

I, the undersigned certify that all information entered on this form is true to the best of my knowledge. I hereby assign all insurance benefits directly to the Med Peds clinic. I authorize the use of this signature on all insurance submissions.

Signature _____ Date _____
Relationship to patient _____