Specialty Outreach Clinics for Children
SCHOOL OF MEDICINE
UNIVERSITY OF COLORADO

In affiliation with Children's Hospital Colorado

REGISTRATION INFORMATION REQUEST FORM

In addition to this form please provide a copy of patient's current insurance card

Patient Information					
Name					
Social Security #					
Date Of Birth		**Gender**		**Marital Status**	
Street Address					
City, State, Zip Code					
Phone Number		**County**			

Patient's Physician Information			
Primary Doctor		**Phone**	
Referring Doctor		**Phone**	
Other Care Provider		**Phone**	

Parent/Guardian/Responsible Person's Information					
Parent/ Guardian/Responsible Party (if not patient)				**Social Security #**	
Parent/ Guardian/Responsible Party's Address					
City, State, Zip Code					
Employer 's Name					
Employer's Address					
City, State, Zip Code					
Home Phone		**Cell Phone**		**Other Phone**	

Please collect the following on CHAMPUS/TRICARE patients			
Sponsor's Duty Station		**Social Security #**	
Sponsor's Branch of Service			
Sponsor's Status	**Active Duty** ☐ **Retired** ☐ **Deceased** ☐		
Sponsor's Grade/Rank			
City, State, Zip Code			

Insurance #1 Information			
Insurance Name			
Cert #		**Group #**	
Insurance Address			
City, State, Zip Code			
Insurance Phone Number			
Subscriber		**Social Security #**	
Relationship to Patient		**Date of Birth**	

Insurance #2 Information			
Insurance Name			
Cert #		**Group #**	
Insurance Address			
City, State, Zip Code			
Insurance Phone Number			
Subscriber		**Social Security #**	
Relationship to Patient		**Date of Birth**	

Attach Label