Family Health Clinic
UNIVERSITY OF COLORADO
SHERIDAN CAMPUS

3525 W. Oxford Ave. Unit G-1
Denver, CO 80236
Office: 303-315-6150
Office Fax: 720-259-4559
Website: www.nursing.ucdenver.edu/sheridan

ADULT PATIENT REGISTRATION FORM

Patient Information

SSN_____

First Name_____ Middle Initial_____

Last Name_____ Preferred Name_____

Suffix_____ Sex at Birth (*check one* ✓): ☐ Male ☐ Female

Gender Identity (*check one* ✓): ■ Male ☐Female ☐Female to Male/Transgender Male

☐Male to Female/Transgender Female ☐Genderqueer/Neither exclusively Male nor Female ☐Other

☐Decline to Report

Sexual Orientation (*check one* ✓): ☐Straight or Heterosexual ☐ Lesbian, Gay, or Homosexual

☐Bisexual ☐Unknown ■Other ☐Decline to Report

Date of Birth____/_____/____

Marital Status (*check one* ✓): ☐Single ☐Married ☐Divorced ☐Legally Separated ☐Widowed

Race (*check all that apply* ✓): ☐White ☐Black/African American ☐Asian ■Hispanic/Latino

☐American Indian/Alaska Native ☐Native Hawaiian/Pacific Islander ☐Other:_____

☐Decline to Report

Ethnicity (*check one* ✓): ☐Latino/Hispanic ☐Not Hispanic or Latino ☐Other ☐Decline to Report

Language Preference: _____

Housing Status (*check one* ✓): ☐Permanent ☐None ☐Unstable ☐Shelter ☐Foster Care

☐Institution

Total Estimated Income: _____ ☐Monthly ☐Annual # Household Size: _____

Employment Information

Employment Status**:** ☐Employed ☐Self-Employed ☐ Unemployed ■ Disabled ☐ Retired ☐Part-time Student ☐Full-time Student

Employer Name_____ Employer Telephone Number_____

Family Health Clinic
UNIVERSITY OF COLORADO
SHERIDAN CAMPUS

3525 W. Oxford Ave. Unit G-1
Denver, CO 80236
Office: 303-315-6150
Office Fax: 720-259-4559
Website: www.nursing.ucdenver.edu/sheridan

Employment Mailing Address_____

City_____ State_____ Zip_____

Contact Information

Mailing Address_____

City_____ State_____ Zip_____

Email_____

Home Phone_____ Mobile Phone_____ Work

Phone_____ Preferred Phone: ☐Home ☐Cell ☐Work

Preferred Method of Communication: ☒Voice ☐Email ☐ Text ☐Don't Contact

May we text you for reminders? ☒Yes ☐No

How did you hear about us? _____

Insurance Information

Do you have insurance? ☒ Yes ☐No Name of Insurance Company_____

Policy #_____

Living With_____

Emergency Contact Information

Relationship to Patient _____First Name_____

Middle Initial_____ Last Name_____ Suffix_____

Mailing Address_____

City_____ State_____ Zip_____

Email_____

Home Phone_____ Mobile Phone_____ Work

Phone_____

Pharmacy Information

Pharmacy_____ Cross Streets _____

Family Health Clinic
UNIVERSITY OF COLORADO
SHERIDAN CAMPUS

3525 W. Oxford Ave. Unit G-1
Denver, CO 80236
Office: 303-315-6150
Office Fax: 720-259-4559
Website: www.nursing.ucdenver.edu/sheridan

The following forms provide you with information about receiving care at Sheridan Health Services. You can receive a copy of each document. Your initials and signature below indicate that you understand the information and agree to the term and conditions outlined below.

csn **Treatment Consent-** This document allows you and any family members 17 and younger to which you are a parent or legal guardian to receive medical, behavioral health and dental treatment at Sheridan Health Services.

_____**HIPAA Notice of Private Practices** – The notice provides information on use of your health information. This form outlines when we will release your health information with or without your consent.

_____**Financial Policy** – This document informs you that Sheridan Health Services expects you to keep your insurance information up-to-date so we may bill for your services when necessary.

_____**Missed and Late Appointment Policy –** This document informs you that after four (4) or more missed or late appointments, Sheridan Health Services may dismiss you from our care.

Patient/Guardian Signature: _____Date:_____