Patient Registration Form

Today's Date _____

Patient Information

Name _____ _____
First Middle Last DOB

Social Security # _____Male_____ Female_____

Street Address _____

City, State, Zip_____

Home Phone _____ Cell _____

E-Mail Address_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow

Race_____ Ethnicity_____

Insurance Information

(Please include a copy of your insurance card) Co-payment is required at the time of service

Insurance Company_____

Member ID #_____ Group #_____

Co-payment amount_____

Policy Holder's Name_____ DOB _____

No Insurance Coverage- We require a minimum payment of $35 at the time service.

Emergency Contact Information

Name _____Relationship _____

Phone _____

Address_____

City, State, Zip _____

Pharmacy Information

Name_____

City, State, Zip_____

Forms may be returned via:

♦Mail to FCHC 310 E. College Dr. Colby, KS 67701.

♦Email to bevans@cmciks.com