



Cheyenne Regional Medical Center

PRE-REGISTER

Admissions is open 7 days a week 24 hours a day. You may also call our pre-admissions line at (307) 633-7630. If no one is available, you may leave your name, phone number and procedure, and a representative from Admissions will return your call.

To pre-register for services at Cheyenne Regional Medical Center, please download the following form and fax it to our Central Admissions Private Fax Line at (307) 432-3100 or bring it with you to your appointment. Please also bring your insurance card and photo ID with you.

Pre-Registration Form

| | |
|--------------------|------------------|
| Your Email Address | *Required Fields |
|--------------------|------------------|

Patient Information

| | | | | | |
|------------------|----------------|--------|---|--|---------------------|
| *Last Name | *First | Middle | *Family Physician's Name | | |
| *Mailing Address | | | *Social Security # | *DOB | Sex |
| *Street Address | | | *Marital Status | | *Religion |
| Apt # | *City | *State | *Zip | *Spanish Speaking? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| *Phone Number | | | Have you been a patient before? <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have an Advanced Directive? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| *Employer | | | *Date of Service | | *Ordering Physician |
| Employer Address | | | *Reason for Test | | |
| City | State | Zip | *Type of Test (X-Ray, Ultrasound, MRI, etc.) | | |
| Occupation | Employer Phone | | *Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No | Auto? <input type="checkbox"/> Yes <input type="checkbox"/> No | Date of Accident |

Guarantor Information

| | | | | | |
|--|-------------------------|--------|--|------------|----------------|
| *Last Name | *First | Middle | *Social Security # | | |
| *Mailing Address (if different from patient) | | | Employer | | |
| Apt. # | City | State | Zip | Occupation | Employer Phone |
| DOB | Relationship to Patient | | Employee Status (Part-Time, Full-Time, etc.) | | |

Insurance Information

Emergency Contact Information

| | | | | | |
|---------------|----------|--|-------------------------|-------|--------|
| *Company Name | | | Last Name | First | Middle |
| *Address | | | Address | | |
| *City | *State | *Zip | City | State | Zip |
| *Insured Name | | | Relationship to Patient | | |
| *Policy # | *Group # | Claim # | Phone Number | | |
| *Phone Number | | *Work Comp? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |