MOUNTAIN REGION FAMILY MEDICINE, PC

PATIENT REGISTRATION FORM

Name_____Social Security Number_____

Address_____

Phone_____Cell_____Marital Status_____

Date of birth_____Age_____Sex_____

Drivers License Number/State_____

Employer_____Student Yes No

Employer address_____

Employer Phone _____Occupation_____

Local Pharmacy_____

Patient's spouse/guardian _____DOB_____

Relationship_____Phone_____ Social Security No._____

Address_____

Employer_____Phone_____

Employer Address_____

Responsible party (if other than patient)/Name_____DOB_____

Address_____

Phone_____Social Security No._____

Employer_____Phone_____

Employer address_____

Emergency Contact (not living with you)/Name_____

Address_____

Phone_____

OVER

Insurance Information (copy of insurance card is also required)

Insurance Company #1_____

Insurance Co. Address/Phone_____

_____

Subscriber_____Phone_____

Subscriber address_____

Subscriber Social Security_____Date of Birth_____

Subscriber Id/Policy No._____

Insurance Company #2_____

Insurance Co. Address/Phone_____

_____

Subscriber_____Phone_____

Subscriber address_____

Subscriber Social Security_____Date of Birth_____

Subscriber Id/Policy No._____

I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether or not covered by insurance. I authorize my insurance carrier to pay Mountain Region Family Medicine, PC any claims filed by them for services for the named patient. I authorize Mountain Region Family Medicine, PC to release medical information requested by my insurance company.

Signature_____Date_____

MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Mountain Region Family Medicine, PC for any services furnished me by Mountain Region Family Medicine, PC. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I request that payment of authorized Medicare benefits be made on my behalf to Mountain Region Family Medicine, PC for any services furnished me by Mountain Region Family Medicine, PC. I authorize any holder of medical information about me to release to my Medigap insurer(s) any information needed to determine these benefits.

Signature_____Date_____