MTN. VIEW FAMILY PRACTICE, PC
REGISTRATION FORM
(Please Print)

PATIENT INFORMATION

Patient's last name:	**First:**	**Middle:**	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Married / Divorced / Widowed

Legal Name? ❑ Yes ❑ No	If not, what is your legal name?	**Maiden Name**:	**Birth date**: / /	Age:	**Sex:** ❑ M ❑ F

Street address:	Social Security no.:	**Phone Number**: ( )

City:	**State**:	**ZIP** Code:	**Okay to leave message?** ❑ **Yes** ❑ **No**

Employer:	Employer phone no:	Additional Contact Number:	**Okay to leave a message?** ❑ **Yes** ❑ **No**

Race:	**Ethnicity: (circle one)** **Hispanic or Latino** **Not Hispanic or Latino**	**Language**:	

How did you hear about us? Name:_____

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Doctor ❑ Other ❑ Insurance Plan ❑ Hospital

Other family members seen here: **Email**:

INSURANCE INFORMATION

Person responsible for bill:	**Birth date:** / /	Address (if different):	Phone no.(if different): ( )

Social Security Number:	Is this person a patient here? ❑ Yes ❑ No

Primary Insurance:	Subscriber's name:	Group no.:	Policy no.:

Subscriber's DOB:	Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child

Secondary Insurance	Subscriber's name:	Group no.:	Policy no.:

Subscriber's DOB:	Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	**Relationship to patient:**	**Home phone no.:** ( )	**Work phone no.:** ( )

OTHERS WE MAY SPEAK WITH ABOUT YOUR CARE

In compliance with HIPAA guidelines, we are unable to disclose or discuss patient's protected health information with anyone other than the patient, unless authorization has been obtained below. You may revoke this authorization at any time.

Name:	**Relationship to Patient:**	**Home phone no:**	**Work phone no:**
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AUTHORIZATION TO RELEASE INFORMATION: I authorize Mtn. View Family Practice, PC to release any medical or incidental information that may be necessary for medical benefit or in processing applications for financial benefit. This includes but is not limited to my insurance company, rehabilitation, specialist for continuation of care, social security administration, and Worker's Compensation.
CONSENT FOR TREATMENT: I authorize Mtn. View Family Practice, PC to administer diagnostic and/or medical procedures necessary for proper health care.
OFFICE POLICY ON PAYMENT: I understand that I (or parent/guardian if patient is a minor) am responsible for payment of all charges incurred at each visit. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, co-payment, co-insurance, or any other balance not paid for by my insurance company. I authorize insurance benefits to be paid directly to Mtn. View Family Practice, PC for services rendered. Full payment of outstanding balances is due within 30 days from date services are reimbursed by my insurance company. If my account is referred to a collection agency, I understand that I may be responsible for additional collection expenses, attorney and/ or court fees.

_____ _____

Patient or Legally Authorized Rep. Signature *Date*

_____ _____

Legally Authorized Rep, (print) *Relationship to Patient*