

Mtn. View Family Practice

Patient Registration Form

Patient Information

Last Name		First Name		Middle Initial
Social Security Number	Date of Birth	Sex	Marital Status	Drivers License or Photo ID

Contact Information

Street Address		City	State	Zip
Home Phone #		Cell Phone #	Work Phone #	Other Phone #
Occupation		Employer	Employer Phone #	
Preferred form of Contact:	<input type="checkbox"/> Home Phone	<input type="checkbox"/> Work Phone	<input type="checkbox"/> Mail/Letter	<input type="checkbox"/> Email/Address: _____
Contact Permissions:	<input type="checkbox"/> Leave message with detailed information		<input type="checkbox"/> Leave message with call back number only	

Insurance Information

Primary Insurance				Policy #	Group #
Subscriber Name		Relationship to Patient		SSN	DOB
Subscriber Employer	Employer Address	City	State	Zip	Employer Phone #
Claims Address		City	State	Zip	
Secondary Insurance				Policy #	Group #
Subscriber Name		Relationship to Patient		SSN	DOB
Subscriber Employer	Employer Address	City	State	Zip	Employer Phone #
Claims Address		City	State	Zip	

Emergency Contact

Contact Name	Relationship to Patient	Home phone #	Work Phone #
Contact Name	Relationship to Patient	Home phone #	Work Phone #

Other's Involved in Healthcare

In compliance with HIPAA regulations, we will be unable to disclose or discuss patient's protected health information with anyone other than the patient, unless authorization has been obtained. If you would like another individual involved in your healthcare, please indicate in the space below. You may revoke this authorization at any time.

Name	Relationship to Patient	Home phone #	Work Phone #
Name	Relationship to Patient	Home phone #	Work Phone #
Name	Relationship to Patient	Home phone #	Work Phone #

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/We authorize Mtn. View Family Practice, PC to administer diagnostic and medical procedures as may be 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. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, co-payment 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 provided. Full payment of outstanding balances is due within 30 days from date services are reimbursed by your insurance company. If my account is referred to a collection agency, I understand that I may be responsible for additional collection expenses, including attorney fees and court costs.

Patient Name (Print)

Date

Patient or Legally Authorized Rep. Signature

Legally Authorized Rep. (Print)

Relationship to Patient