Mtn. View Family Practice, PC
Registration Form

(Please Print Legibly)

PATIENT INFORMATION

Patient's Legal Last Name:	**Legal First:**	**Middle Initial:**	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	**Marital status** (circle one) S M D W DP

Preferred Name:	**Maiden Name**:	**Birth date**: / /	**Sex at Birth**: ❑ M ❑ F	**Gender:** ❑ M ❑ F

Street address: ❑Physical ❑Mailing	**Apt/Unit #:**	**Social Security No:**

City:	**State**:	**ZIP Code:**	**Primary Phone Number** ( )	**Voice Message Okay?** ❑ Yes ❑ No	**Text Message Okay?** ❑ Yes ❑ No

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

Race:	**Ethnicity: (circle one)** Hispanic/Latino Not Hispanic/Latino	**Preferred Language**:	**Interpreter Needed?** ❑ Yes ❑ No

How did you hear about us?	**Email:**

BILLING INFORMATION

Person responsible for bill: ❑Self If patient is a minor, name of responsible party:	**Birth date:** / /	Address (if different from above):	Phone no.(if different from above): ( )

Primary Insurance:	Subscriber:❑Self	Birth date:	SSN:
Secondary Insurance:	Subscriber:	Birth date:	SSN:

IN CASE OF EMERGENCY

Name of local friend or relative:	**Relationship to patient:**	**Primary Phone Number:** ( )	**Alternate Phone Number:** ( )

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:**	**Primary Phone Number:**	**Alternate Phone Number:**
Name:	**Relationship to Patient:**	**Primary Phone Number:**	**Alternate Phone Number:**

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 of 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.

X_____ _____

Patient Signature ***Date***

(Legally Authorized Representative for Patient)

_____ _____

Legally Authorized Rep Name (please print) ***Relationship to Patient***