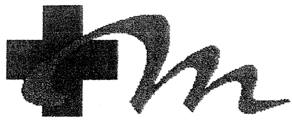

Mountain Medical Immediate Care
Patient Registration Form

PATIENT INFORMATION

Name:________________________________ Date of Birth:__________ SS#: ________________

Mailing Address:____ Phone#: ________________

City: ____________________________________ State:________________ Zip: ____________

Male ____ Female ______ Cell or Local Phone: ___________________ Email: ________________

Marital Status: Single ______ Married ______ Divorced _______ Separated _______ Widowed _______

Employer:____ Phone#: _______________

PARENT/GUARDIAN INFORMATION

Name:_____________________________________ Date of Birth:__________ SS#: ___________

Mailing Address:____ Phone#: ________________

City: ____________________________________ State:________________ Zip: ____________

Gender: Male _________ Female ________ Cell or Local Phone: _________________________

Marital Status: Single ______ Married ______ Other ______

Employer:____ Phone#: _______________

Relationship to Patient: __________________________________ Local Phone#: _______________

REASON FOR VISIT

Illness _____ Injury _____ Job Related Injury _____ Auto Accident _____ Other _____

Date of Injury or onset of problem:____

Explain symptoms:____

EMERGENCY CONTACT

Name:____ Relationship to Patient: ____________

Address: ____ Phone#: _______________

City *State* *Zip*

PRIMARY INSURANCE INFORMATION

Insurance Company: ______________________________ Phone#: ______________

Address: ____

Group#: ______________________ ID#: ______________________

Name of Insured : ______________________ Date of Birth: ________ SS#: ____________

Relationship to Patient: ______________________ Employer: ______________________

SECONDARY INSURANCE INFORMATION (*if applicable*)

Insurance Company: ______________________________ Phone#: ______________

Address: ____

Group#: ______________________ ID#: ______________________

Name of Insured: ______________________ Date of Birth: ________ SS#: ____________

Relationship to Patient: ______________________ Employer: ______________________

MISCELLANEOUS PATIENT INFORMATION

Primary Care Physician: ______________________________ Phone#: ______________

PLEASE READ, SIGN AND RETURN TO THE RECEPTIONIST

AGREEMENT FOR FINANCIAL RESPONSIBILITY: I understand that Mountain Medical Group bills insurance companies ONLY AS A COURTESY and that I am financially responsible for all charges incurred including, but not limited to, outside lab work and x-ray readings. If it becomes necessary to effect collections of any amount owed on this or subsequent visits the undersigned agrees to pay for all cost and expenses, including any service charges, collection & attorney fees. I hereby authorize the doctor to release information necessary to secure payment of benefits.

CONSENT FOR TREATMENT: I hereby consent to, and authorize, all treatment that may be considered necessary or advisable by the provider and certify that no guarantee or assurance has been made as to the results which may be obtained. I understand that if hospitalization or further treatment is required the center will attempt to contact the patient's selected physician to provide the service.

ASSIGNMENT OF BENEFITS: I authorize payment of Medical Benefits to Mountain Medical Group. I authorize the release of any medical or other information necessary to collect payment for services rendered.

Signature: ______________________________________ Date: ______________