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# PATIENT INFORMATION

Patient Name:________________________________ Sex: ________ Marital Status: ______________

Date of Birth: ______________________ Social Sec. No. ____________________________________

Address: ______________________________________________________________________

City: __________________________________ State: _________________ Zip: ________________

Home Phone: ____________________________ Mobile Phone: ____________________________

Email: _________________________________________________________________________

Employer: _______________________________ Phone: __________________________________

Emergency Contact Name: _____________________________ Home Phone: ___________________

Mobile Phone: _________________________ Relation: ____________________________________

Referred by: __________Sales __________Provider __________Friend

## PERSONAL MEDICAL INSURANCE INFORMATION:

Insurance Company: _____________________________ Group Number: _______________________
Policy Number: __________________________ Insurance Phone Number: _______________________
Claims Address: ______________________________________________________________________
Type of Policy: (**please circle one of the following)** PPO HMO

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**CONSENT FOR TEST RESULTS:** I give **Mountain Medical** permission to leave all Imaging/Lab results, appointments and other medical information and advice on (**circle below all that apply**)
Voicemail at Work/Home/Cell **OR** DO NOT LEAVE MESSAGE **OR** Email
Okay to leave message with family member? ( If so, List name and relation)_____________________
Okay to receive Email appointment reminders? Y/N Specials or promotions? Y/N

**Please phone 24 hours prior to a scheduled appointment to cancel or reschedule an appointment or you will be charged 1/2 of the price of scheduled visit.** You will be required to pay for missed appointments at your next appointment. **We honor Credit, Check or Cash for visits**. If a check or credit card payment is returned you will be charged $35 and must pay in cash in the future. ***All unpaid charges are due before or at time of next scheduled appointment.*** ***All cash pay prices are subject to change to regular office visit prices if not paid at time of service.***

***By signing below you are confirming that the information you have provided is correct and true to the best of your knowledge. I hereby acknowledge that I have received a copy of Mountain Medicals Notice of Privacy Practices. I authorize the release of any medical information and payment of medical benefits to the undersigned physician or supplier for services necessary to process a claim. I agree to be responsible for any deductible, co-insurance, co-pay or any other balance not paid by insurance or settlement.***

**Patient Name:**_________________________________________ **Date:** ________________
**Signature:** ______________________________________ **Relation to Patient:** ____________