Mountain Medical Center

Date____/____/_____

PATIENT INFORMATION:

Last________________ Suffix ___ First________________ Middle__________ Preferred Name__________

Mailing Address___________________________ Physical Address (if different)________________________

City_____________________________________ State____________________ Zip Code_________________

Home Phone___________________ Work Phone_____________________ Cell Phone___________________

Email Address (used for patient portal access & appointment reminders)_______________________________

Date of Birth_____/_____/________ Sex______ Gender______ Social Security Number_____-____-______

Marital Status.......................... □ Single □ Married □ Divorced □ Widowed

Preferred Language.................... □ English □ Spanish □ Other_________________

Race..................................... □ American Indian or Alaska Native □ Asian □ Black or African American

□ Native Hawaiian or Other Pacific Islander □ White □ Undisclosed

Ethnicity................................ □ Hispanic or Latino □ Not Hispanic or Latino

Do you give your consent to access your medical records though an online, secured patient portal? □ Yes □ No

Do you have an Advance Directive? □ Yes □ No (Please bring to your first office visit if yes)

Do you have any visual or hearing needs, preferences, or limitations? □ Yes □ No □ Explain________________

INSURANCE INFORMATION:

□ Check if uninsured (self-pay) and skip section

Primary Insurance Company Name______________________________Coverage Start Date______________

Subscriber ID#___________________________ Group #_____________PCP Co-Pay Amt $______________

Subscriber Name (if different than patient)_________________________ Subscriber DOB: ____/____/_____

Secondary / Supplemental Insurance Name (if applicable)____

Subscriber ID#___________________________ Group #_____________PCP Co-Pay Amt $______________

RESPONSIBLE PARTY: (WHO DO WE BILL?)

□ Check if patient is financial guarantor & skip section

Name__________________________________ Phone Number______________________

Date of Birth_________/__________/___________ Social Security Number________-_________-________

Relation to Patient? □ parent □ spouse □ employer □ other ______________________

EMERGENCY CONTACT:

□ Check if same as responsible party & skip section

Name__________________________________ Relationship to patient________________

Address____Phone #________________________