MOUNTAINSTAR Medical Group

Patient Registration Form

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr. ☐ Other _____

Patient's Name (Last) _____ _____ (First) _____ (Middle) _____

Also Known As Name (Last) _____ (First) _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other _____

Social Security Number _____-_____ -_____ Date of Birth _____ /_____ /_____ ☐Female ☐Male

Phone Numbers Home _____ Cellular_____ Work _____

Preferred contact number ☐ Home ☐ Cell ☐ Work

Email Address: _____

Address _____

City, State, ZIP _____

Local Pharmacy Name & Number _____ Mail Order Pharmacy Name _____

Employment Status ☐ Employed Full-Time / Part-Time ☐ Unemployed ☐ Student Full-Time / Part-Time ☐Retired

Employer _____ Occupation _____

Emergency Contact Name _____ Phone Number _____

Relationship to Patient _____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (Last) _____ _____ (First) _____ (Middle) _____

Also Known As Name (Last) _____ (First) _____

Social Security Number _____-_____ -_____ Date of Birth _____ /_____ /_____ ☐Female ☐Male

Phone Numbers Home _____ Cellular_____ Work _____

Preferred contact number ☐ Home ☐ Cell ☐ Work

Email Address: _____

Address _____

City, State, ZIP _____

Employment Status ☐ Employed Full-Time / Part-Time ☐ Unemployed ☐ Student Full-Time / Part-Time ☐Retired

Employer Name & Number _____ Occupation _____

Patient Relationship to Responsible Party _____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk)

Name of Insured _____ Patient Relationship to Insured _____

Insured Date of Birth _____ /_____ /_____ Insured Social Security Number _____

Insurance Company/Phone Number _____ (_____)_____

Subscriber ID (Policy Number) _____ Group ID _____ Co-pay Amount _____

Effective Date _____ ☐ Female ☐Male

Insurance Company Address _____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk)

Name of Insured _____ Patient Relationship to Insured _____

Insured Date of Birth _____ /_____ /_____ Insured Social Security Number _____

Insurance Company/Phone Number _____ (_____)_____

Subscriber ID (Policy Number) _____ Group ID _____ Co-pay Amount _____

Insurance Company Address _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ ***Date*** _____