Colorado Mountain Medical

Patient Registration Form **Patient Acct #:**_____

PATIENT

Patient's Name: Last **First(legal):** **Middle Initial:**

Mailing Address:

City: **State:** **Zip:**

Sex: ☐ Male ☐ Female **Marital Status**: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Date of Birth: MM/DD/YY **Age:** **Email Address**:

Home Phone #: **Work #:** **Ext#:** **Cell #:**

Employer: **Address:**

Ethnicity
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unreported/Refused to Report

Race
☐ White
☐ Asian
☐ Pacific Islander
☐ Black/African American
☐ Native Hawaiian
☐ American Indian or Alaskan Native
☐ More than one race
☐ Unreported/Refused to Report

Best Contact number
☐ Home ☐ Cell
☐ Work **May we leave message** Yes/No

Preferred Language
_____

Pharmacy Name: **Street/City:** **Phone:**

Mail Order Pharmacy Name: **Phone:**

Family Physician Name: _____ **Phone**: _____

Referring Physician Name: _____ **Phone:** _____

Emergency Contact Name: _____ **Phone:**_____
Relationship: ☐Father ☐Mother ☐Guardian ☐Sibling ☐Child ☐ Other

**** Please present your insurance card and photo ID to the receptionist ****

INSURANCE

Primary Insurance:_____
ID #_____**Group#**_____

Subscriber's Name: _____ **DOB:** _____

Subscriber Address:_____
Relationship to Patient ☐ Self ☐ Spouse ☐Father ☐ Mother ☐ Guardian ☐ Other

Secondary Insurance: _____

Subscriber's Name: _____ **DOB**: _____ **SSN:** _____

Relationship to Patient ☐ Self ☐ Spouse ☐Father ☐ Mother ☐ Guardian ☐ Other

Has a Worker's Compensation claim been filed for this injury? ☐ Yes ☐ No **If Yes, Date of Injury**: _____

Workers' Comp Insurance Carrier: _____ **Adjuster Name & Phone**: _____
*Approval must be given by your employer, Nurse Case Manager or Adjuster **before** your appointment. All appointments made without prior approval will be rescheduled.

FINANCE

Responsible Party (for patients who are under age 18)
Name-Last: **First: (legal):** **Middle Initial:**

Address: (if different than patient)

City: **State:** **Zip:**

Date of Birth:

Phone #: **Relationship to patient:** ☐Father ☐ Mother ☐ Guardian

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