PATIENT REGISTRATION

Date:_____ Referred by Dr.:_____

Drug Allergies:_____ Has any of your family been treated here? Who:_____

If your injury took place at work please notify the receptionist

PATIENT INFORMATION

Patient's Name:_____ Soc. Sec. #_____
Last First Middle

Date of Birth:_____ Age____ Sex____ Marital Status:_____
Mo. Day Yr.

Mailing Address:_____
Street /PO Box City State Zip

Home Phone: (_____)_____ Cell Phone: (_____)_____

Email Address:_____

Appointment reminders (check all that apply) ☐ **TEXT** ☐ **EMAIL** ☐ **AUTOMATED VOICE**

RESPONSIBLE PARTY INFORMATION

☐ **SELF**

Primary Policy Holder:_____ Relationship to Patient:_____

Date of Birth:_____ Phone #_____ Soc Sec. #_____

Mailing Address:_____
Street/PO Box City State Zip

INSURANCE INFORMATION

COPY OF INSURANCE CARDS REQUIRED AT TIME OF SERVICE

EMERGENCY INFO

EMERGENCY CONTACT

Name:_____ Phone Number:(_____)_____

Relationship:_____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies may pay fixed allowances for certain procedures; they may refer to these as "Reasonable and customary fees". We do not accept this as payment in full unless otherwise restricted by law or agreement we may have with your insurer. Also, some of the insurance companies only pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance. IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE DO REQUEST THAT OUR CHARGE FOR OFFICE VISITS BE PAID AT THE INITATION OF EACH VISIT.

In the event the account is turned over for collection, the collection fees and/or legal fees, including attorney's fees up to 35%, shall be your responsibility. I hereby assign all medical and/or surgical benefits; to include major medical benefits to which I am entitled, Medicare, private insurance and other health plans to:
Mountain West Family Practice, 2356 N 400 E, Ste 201, Tooele UT 84074

This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid and original. I hereby authorize said assignee to release all information necessary to secure payment, via Fax Transmittal or hand copy.

PATIENT NAME (print):_____

SIGNATURE (patient or patient representative):_____ **DATE:**_____