

Rocky Mountain Family Physicians, P.C.

PATIENT INFORMATION FORM

Today's Date:			PCP:		
PATIENT INFORMATION					
Patient's Last Name:		First:	Middle:	Social Security Number:	
Address:		City:	State:	Zip Code:	Birth Date: Sex: <input type="radio"/> M <input type="radio"/> F
Email Address (This will be used for billing purposes):					
Marital Status:		Cell Phone Number:		Alternative Phone Number:	
Employer:		Ok to leave detailed message: <input type="radio"/> Yes <input type="radio"/> No		Ok to leave detailed message: <input type="radio"/> Yes <input type="radio"/> No	
How did you hear about us? _____					
BILLING INFORMATION					
(Please provide your insurance card to the receptionist)					
Person responsible for bill:		Birth date:	Address (if different):		Cell Phone Number:
Is this person a patient here? <input type="radio"/> Yes <input type="radio"/> No		Relationship:			
IN CASE OF EMERGENCY					
Name of local friend or relative:			Relationship to patient:	Home Phone No.:	Work Phone No.:
<p>I consent to Rocky Mountain Family Physicians' use and disclosure of my Protected Health Information to carry out treatment, payment, and healthcare operations.</p> <p>I acknowledge that the Privacy Practices of Rocky Mountain Family Physicians was made available for my review.</p> <p>I have reviewed the financial policy and agree to follow the guidelines set forth therein.</p> <p style="text-align: center;">I give my permission to release all my medical-related information to the following person(s):</p> <p>Name: _____ Relationship: _____</p> <p>Name: _____ Relationship: _____</p> <p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Rocky Mountain Family Physicians, P.C. to release any information required to process my claims.</p>					
_____ Patient/Guardian signature			_____ Date		