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: M F

Email Address (This will be used for billing purposes):

Marital Status:	Cell Phone Number:	Alternative Phone Number:
Employer:	Ok to leave detailed message: Yes No	Ok to leave detailed message: Yes 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?	Yes No	Relationship:	

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home Phone No.:	Work Phone No.:

I consent to Rocky Mountain Family Physicians' use and disclosure of my Protected Health Information to carry out treatment, payment, and healthcare operations.

I acknowledge that the Privacy Practices of Rocky Mountain Family Physicians was made available for my review.

I have reviewed the financial policy and agree to follow the guidelines set forth therein.

I give my permission to release all my medical-related information to the following person(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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.

_____ _____

Patient (18 years or older) or Legal Guardian Signature **Date**