MOUNTAIN WEST DERMATOLOGY, PC

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Patient Registration Form

Office Use Only

___NP ___ EST

___Updated ___Scanned

Please print in black ink and complete ALL BLANKS

Patient Name: _____
Last Name *First Name* *M.I.*

Home Address: _____
Street *City* *State* *Zip*

Primary Phone # _____ **Secondary Phone #** _____

Mailing Address: _____
If different than home address

Email Address: _____ **Social Security #** _____

DOB: ___/___/___ **Sex:** _____ **Marital Status:** Married Single Divorced Widowed *(Circle One)*

Name of responsible party: _____ **Address:** _____

Emergency Contact Name: _____ **Phone #:** _____ **Relationship:** _____

Primary Care Provider: _____

REQUIRED – CURRENT INSURANCE COMPANY INFORMATION / PRIMARY

Insurance Company # 1: _____ **ID #:** _____

Group #: _____ **Subscriber Name:** _____ **DOB:** ___/___/___ **Relationship:** _____

REQUIRED IF APPLICABLE – CURRENT INSURANCE COMPANY INFORMATION / SECONDARY

Insurance Company # 2: _____ **ID #:** _____

Group #: _____ **Subscriber Name:** _____ **DOB:** ___/___/___ **Relationship:** _____

Ethnicity:
Caucasian/White
African American
Hispanic
Asian
Other _____
Prefer not to specify

Preferred Language:
English
Spanish
Other _____

PREFERRED PHARMACY Name of Pharmacy _____ Location _____

RELEASE OF INFORMATION: I authorize the release of my medical information to my primary care or referring physician, to consultants and as needed to process insurance claims and prescriptions. I also authorize payment of medical benefits to the physician. I understand that I am financially responsible for any balance not covered by my insurance, and a $10.00 Processing Fee may be assessed if copayments are not paid at time of service.

Patient or Responsible Party Signature _____ **Date** ____/____/____

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