MOUNTAIN WEST DERMATOLOGY, PC

L. Arthur Weber, M.D., Lewis J. Kirkegaard, M.D., Matthew J. Deeths, M.D., Ph.D., Amy Y. Paul, D.O., Matthew R. Donaldson, M.D., Travis J. Morrell, M.D., M.P.H., Caroline W. Laggis, M.D.

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:** _____

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** ____/____/____

Rev. 06-02-22