Mountain West Dermatology, P.C.

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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 # ____/____/_____
(Circle one)
Birthday ____/____/____ Age _____ Sex _____ Marital Status M S D W

Responsible Party or Spouse's Name _____

Address _____ Phone # _____

Emergency Contact Name_____Phone#_____Relationship_____

Referred by _____ Primary Care Provider_____
(Personal physician, friend, website, etc.)

How did you hear about our office? _____

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. 03.30.22