New Patient Registration Information

Please PRINT AND complete ALL sections below!

PATIENT'S PERSONAL INFORMATION

Marital Status: Single Married Divorced Widowed **Sex:** Male Female

Name: ________________ (last name) ________________ (first name) ______ (initial)

Date of Birth: ______ / ______ / ______ Social Security #: ______ - ______ - ______

Home Phone: (_____) ________________ Work Phone: (_____) ________________ Cell Phone: (_____) ________________

Address: ________________ Apt. #: ______ City: ________________ State: ____ Zip: ________

PATIENT 'S / RESPONSIBLE PARTY INFORMATION

Relationship to Patient: Self Spouse Child Other:

Name: ________________ (last name) ________________ (first name) ______ (initial)

Date of Birth: ______ / ______ / ______ Social Security #: ______ - ______ - ______

Home Phone: (_____) ________________ Work Phone: (_____) ________________ Cell Phone: (_____) ________________

Address: ________________ Apt. #: ______ City: ________________ State: ____ Zip: ________

PATIENT'S INSURANCE INFORMATION

Please present insurance cards to receptionist.

PRIMARY Insurance Name: ________________

Address: ________________ City: ________________ State: ____ Zip: ________

Name of insured: ________________ Date of Birth: ________ Relationship to insured: Self Spouse Child Other

Policy #: ________________ Group #: ________________ Copay: $ ________

SECONDARY Insurance Name: ________________

Address: ________________ City: ________________ State: ____ Zip: ________

Name of insured: ________________ Date of Birth: ________ Relationship to insured: Self Spouse Child Other

Policy #: ________________ Group #: ________________ Copay: $ ________

PATIENT'S ACCES TO CARE INFORMATION

To comply with our open access regulations and policies, we request this information

Ethnicity: Caucasian African-American Asian-American Native American Hispanic Other:____________

Preferred Language**:** English Spanish Other: ________________ Translator needed?: Yes No

Other possible barriers to care: ________________

PHARMACY INFORMATION

This will serve as your preferred pharmacy for electronic submission of prescrptions

Name: ________________

Address: ________________ City: ________________ State: ____ Zip: ________

Phone: (_____) ________________ Fax: (_____) ________________

Emergency Contact

Name: ________________ Relationship: ________

Address: ________________ City: ________________ State: ____ Zip: ________

Home Phone: (_____) ________________ Work Phone: (_____) ________________ Cell Phone: (_____) ________________

Assignment of Benefits • Financial Agreement and Test Results Communication

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Mile High Primary Care, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I also authorize Mile High Primary Care to leave voicemail messages or messages with family members concerning non-sensitive medical test results at my home or preferred phone number.

I further agree that a photocopy of this agreement shall be as valid as the original.

Date: ________________ Your Signature: ________________________________