



**** IMPORTANT ****

IF YOU WOULD LIKE SOMEONE OTHER THAN YOURSELF AND YOUR DOCTOR TO BE ABLE TO ACCESS YOUR RECORDS YOU MUST FILL OUT A RELEASE FORM. YOU CAN ASK FOR ONE AT THE FRONT DESK.

NAME: _____ SEX: _____ DATE OF BIRTH: _____

ADDRESS: _____
STREET CITY STATE ZIP

HOME # _____ CELL # _____ WORK # _____

SOCIAL SECURITY # _____

MARITAL STATUS: MARRIED SINGLE DIVORCED WIDOWED OTHER

EMERGENCY CONTACT: _____ PHONE: _____

MINOR INFORMATION

PARENT/LEGAL GUARDIAN: _____ PHONE: _____

ADDRESS: _____ RELATIONSHIP TO PATIENT: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ POLICY HOLDER: _____

INSURANCE ADDRESS: _____
STREET CITY STATE ZIP

POLICY # _____ GROUP # _____

SECONDARY INSURANCE: _____ POLICY HOLDER: _____

INSURANCE ADDRESS: _____
STREET CITY STATE ZIP

POLICY # _____ GROUP # _____

WORKERS COMPENSATION OR AUTO CLAIMS

DATE OF INJURY: _____ AUTO INJURY WORKERS COMP INJURY

This is a written acknowledgment that I have been presented Mountain Medical's notice of privacy practices for my review.

SIGNATURE

DATE