Patient Information

Patient Name: ____ **SSN:** ____________________

Date of Birth: ____ **Sex:** ☐ Male ☐ Female

Address: ____________________________ **Apt#:** _____ **City:** ___________ **State:** ____ **Zip:** ______

Home #: ____________________ **Work #:** ____________________ **Cell#:** ____________________

Email: ____ ☐Home ☐Cell ☐Work ☐Email

Your feedback is important to us. We would like to send you a short survey about this visit.
Your information will not be shared.

Preferred contact method

The federal government now requires more detailed patient information. All information given is confidential and used for internal purposes only.

Preferred Language: _______________ **Ethnicity:** Hispanic/Latino / Not Hispanic/Latino / Declined

Race: American Indian-Alaskan Native / Asian / Black-African American / Native Hawaiian-Pacific Islander/ White / Declined

Smoking status: ☐ Current (☐ Everyday ☐ Some days) ☐ Former ☐ Never ☐ Decline

Height ____________________ **Weight** ____________________

I agree I am financially responsible for services rendered by MMIC including any deductibles, co-insurance, or co-pays.

(Please sign) ____ **Relationship** ____________________

Worker's Compensation/Auto

Worker's Compensation/Auto ______________________________ **Date of Injury** ____________________

Emergency Contact: (*Please use additional phone information, different from above.)*

Name: ____________________ **Phone #:** ____________________ **Relation:** ______________

I authorize Mountain Medical to discuss or send my medical information to the following persons:
(Family members: Spouse, Parents, Kids, and Friends etc)

1. ____________________________ **Phone:** ____________________ **Relation:** ______________

2. ____________________________ **Fax #:** ____________________

Please sign: ____ **Expiration Date:** ____________________

I have received a Notice of Privacy Practices and I have been provided an opportunity to review it.
(Located at the front desk)

Please sign: ____ **Date:** ____________________