Colorado Mountain Medical

Patient Registration Form　　　Patient Acct#:________________

PATIENT

Patient's Name: Last　　First(legal):　　Middle Initial:

Mailing Address:	City:	State:	ZIP:
Physical Address:	City:	State:	ZIP:

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

Date of Birth: MM/DD/YY　　Age:　　Email Address:

Home Phone #:　　Work #: Ext#　　Cell #:

Employer:　　Address:

Ethnicity
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unreported/Refused to Report

Race
- ☐ White
- ☐ Asian
- ☐ Pacific Islander
- ☐ Black/African American
- ☐ Native Hawaiian
- ☐ American Indian or Alaskan Native
- ☐ More than one race
- ☐ Unreported/Refused to Report

Best Contact number:
☐ Home ☐ Cell
☐ Work
May we leave message? Yes or No

Preferred Language
____

Pharmacy Name:　　Street/City:　　Phone:

Mail Order Pharmacy Name:　　Phone:

Family Physician Name: ____ Phone: ______________________________________
Referring Physician Name: ______________________________________ Phone: ______________________________________

Emergency Contact Name: ______________________________________ Phone:______________________________________
Relationship: ☐ Father ☐ Mother ☐ Guardian ☐ Spouse ☐ Child ☐ Other
Guarantor: ______________________________ DOB: __________________
Relationship: ☐ Father ☐ Mother ☐ Guardian ☐ Spouse ☐ Other

**** Please present your insurance card and photo ID to the receptionist ****

INSURANCE

Primary Insurance: _______________________________________
ID #___________________________________Group#___________________

Subscriber's Name: __________________________________ DOB: _____________
Subscriber Address:____

Relationship to Patient ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Guardian ☐ Other

Secondary Insurance: _____________________________________
Subscriber's Name: __________________________________ DOB: _______________ SSN: __________________________
Relationship to Patient ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Guardian ☐ Other

Has a Worker's Compensation claim been filed for this injury? ☐ Yes ☐ No　If Yes, Date of Injury: _________________________

Workers' Comp Insurance Carrier: __________________________________ Adjuster Name & Phone: _________________________________

*Approval must be given by your employer, Nurse Case Manager or Adjuster **before** your appointment. All appointments made without prior approval will be rescheduled.

FINANCE

Responsible Party (for patients who are under age 18)

Name-Last:　　First: (legal):　　Middle Initial:

Address: (if different than patient)

City:	State:	Zip:
Date of Birth:		
Phone #:	Relationship to patient: ☐ Father ☐ Mother ☐ Guardian	