PATIENT REGISTRATION FORM

Indian Peaks Medical Group Inc

(Print clearly & press firmly in black ink)

Today's Date_____

Patient Name_____
Last First MI Nickname

Date of Birth _____ SSN _____ Gender (circle) F M

Address _____
Street Apt/Ste City State Zip

E-Mail _____

Primary Phone ( )_____ May we leave a message? (circle) YES / NO

Secondary Phone ( )_____ May we leave a message? (circle) YES / NO

Work Phone ( )_____ OK to call work? (circle) YES / NO

Patient's Employer_____

Primary reason for today's visit_____

_____

Primary Care Physician_____ Referring Physician_____
Last First Last First

Is this work-related? (circle) YES NO Related to an auto accident? (circle) YES NO *If YES on EITHER, please complete Auto/WC Form*

Current insurance card(s) and photo identification are required for scanning. Please complete the following:

Primary Insurance _____ Policy #/ID _____ Group # _____

Name of Policy Holder _____ SSN _____ Date of Birth _____ Gender (circle) F M

Relationship to Patient_____ Employer _____ Employer Phone ( )_____

Secondary Insurance _____ Policy #/ID _____ Group # _____

Name of Policy Holder _____ SSN _____ Date of Birth _____ Gender (circle) F M

Relationship to Patient_____ Employer _____ Employer Phone ( )_____

If you are a Medicare beneficiary, please circle any of the following that apply to you:

(circle) Working-Aged ESRD Auto/Med/No Fault Liability Workers Comp Federal Black Lung Veterans Affairs Disability Other Liability

If you do not have insurance, have you applied for government assistance? (circle) YES NO If yes, provide social worker's information.

Social Worker's Name_____ Phone ( )_____

If patient is a minor, name of Custodial Parent _____

Custodial Parent's Primary Phone( )_____ Secondary Phone( )_____

Custodial Parent's SSN_____ Date of Birth_____

Emergency Contact – Close friend or relative not living with you that we can contact in an emergency:

Name _____ Relationship _____ Phone( )_____
Last First

Name of person we may speak with other than yourself regarding your medical care?_____

Primary Phone( )_____ Secondary Phone( )_____ Relationship_____