MOUNTAIN VIEW FAMILY MEDICINE

Patient Information:

Patient Name:____ DOB:________________

Address:____Zip:________________

Home Phone:___________________________Cell Phone:________________________________

SS#:__________________________Marital Status:________________Sex:________________

Race:__________________________Ethnicity:____________________Language:____________

Employer:____Work Phone:____________

Employer Address:____Zip:________________

Emergency Contact:____Phone:______________

Guarantor Information:

Name:_______________________________Relationship to Patient:_________________________

Address:____Zip:________________

Home Phone:___________________________Cell Phone:________________________________

SS#:__________________________Marital Status:_________________Sex:_______________

Race:__________________________Ethnicity:_____________________Language:___________

Employer:____Work Phone:___________

Employer Address:____Zip:_______________

Insurance Information:

(1) Name of Insurance:____

Policy Holder Name:_____________________________Policy Holders DOB:________________

Relationship to Patient:___________________________Effective Date of Coverage:___________

Identification Number:____________________________Group Number:____________________

(2) Name of Insurance:____

Policy Holder Name:_____________________________Policy Holders DOB:_______________

Relationship to Patient:___________________________ Effective Date of Coverage:__________

Identification Number:____________________________Group Number:___________________

I have received and reviewed a copy of the privacy policy at Mountain View Family Medicine.

Signed:__________________________________Date:________________

Consent to treat

As either the patient or the legal authorized representative of the patient, the following consents, understandings, and agreements are made on my own behalf or on behalf of the patient in partial consideration of the health care services to be provided to the patient at Mountain View Family Medicine.

I hereby give consent to Mountain View Family Medicine, its contractors, medical staff and employees to provide health care services and to administer physician orders for my benefit for this visit and my subsequent visits, and I understand that this consent may be revoked in writing at any time. I understood that there is risk of substantial and serious harm involved in such health care services, and this risk is accepted in hope of obtaining beneficial results from these services. No promises on any particular outcome or successful result have been made, and I understand and accept that there is some uncertainty involved in the outcome of health care services for which this consent is given. The physicians and our office are separately responsible to explain what they do and, in some cases, they may obtain a separate consent for services provided.

Assignment of Benefits

I hereby assign all medical/surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and any other health plans to Mountain View Family Medicine, Inc.

Authorization to release information and Financial Responsibility

This order will remain in effect until revoked by me in writing. A photocopy is not to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize Mountain View Family Medicine to release information necessary for treatment, payment or operations.

Signed_________________________________ **Date**_______________________________