

Rocky Mountain Primary Care

Patient Information

Last Name _____	First Name _____	MRN _____
SS# _____	Birthdate _____	Sex _____
Email Address _____		
Address _____		
City, State, Zip _____	Home Phone _____	Cell Phone _____
Primary Care Physician _____	Referring Physician _____	
Primary Employer _____	Secondary Employer _____	
Address _____	Address _____	
City, State, Zip _____	City, State, Zip _____	
Work Phone _____	Work Phone _____	

Responsible Party Information

Last Name _____	First Name _____	SS# _____
Birthdate _____	Sex _____	Relationship to Patient _____
Address _____		
City, State, Zip _____		
Home Phone _____		

Primary Insurance Company

Name of Insurance _____	Policy # _____	
Name of Insured _____	Group # _____	
Address of Ins Co. _____	Copay Amt _____	
City, State, Zip _____	Deductible _____	
Relationship to Patient _____	Effective Date _____	Expiration date _____

Secondary Insurance Company

Name of Insurance _____	Policy # _____	
Name of Insured _____	Group # _____	
Address of Ins Co. _____	Copay Amt _____	
City, State, Zip _____	Deductible _____	
Relationship to Patient _____	Effective Date _____	Expiration date _____

Accident Related? Yes _____ No _____	Auto _____	Case/Claim# _____
Date of Accident _____	Adjusters Name _____	Phone _____
If work related, has employer been notified? _____		
Contact _____		

I authorize the release of my medical information to process my claims and request payment of benefits to the above physicians. Regardless of my insurance status, I am responsible for any unpaid charges incurred for services rendered. Payment is expected in full upon receipt of statement or arrangements must be made with the business office. Failure to keep a scheduled appointment may result in charges for an office visit. I am also responsible for any court costs or attorney fees incurred to collect such outstanding balances.

Signature of Patient/Guardian _____ Date _____