High Mountain Healthcare, LLC

*Today's Date:*_____

ADULT PATIENT INFORMATION SHEET- Annual Update

Patient's Last Name_____ First_____ Middle Initial_____

Mailing Address_____ City/State/Zip_____

Hm Phone(____)_____ Wk Phone(____)_____ Cell(___)_____

Birthdate_____ Soc. Sec. Nbr. _____ Male_____ Female_____

E-Mail_____ Marital Status: M S D W Employed by:_____

Race_____ Ethnicity_____ Preferred Language_____

Insurance Information
(Please provide a copy of your cards)

Primary Insurance Company Name_____

Secondary Insurance Company Name_____

Third Insurance Company Name _____

IF INSURANCE HOLDER IS DIFFERENT FROM PATIENT:

Insurance Holder's Name_____ Relation to patient_____

Mailing Address_____ City/State/Zip_____

Hm Phone(____)_____ Wk Phone(____)_____ Cell(___)_____

Birthdate_____ Soc. Sec# _____ Male_____ Female_____

E-Mail_____ Marital Status: M S D W Employed by:_____

EMERGENCY CONTACT (someone other than a person that would be in your household):

Name_____ Relationship to patient_____
Address_____ City/State/Zip_____
Hm Phone(____)_____ Wk Phone(____)_____ Cell(___)_____

I certify that the above information is correct. I understand the office financial policies and procedures. I understand that High Mountain Healthcare reserves the right to add a 10% collection fee and any additional attorney fees that may apply to my account if it is forwarded to a collection agency.

Patient Signature_____

Adult Medical Information and Treatment Release Form

Patient Name:_____ DOB:_____

My medical information may be released to:

____Spouse _____

____Child/Children _____

____Other_____

____Parent(s)_____

___I authorize messages regarding my medical care to be left on any phone number that I have provided.

___I authorize the release of information including the diagnosis, records, claims information, and examination rendered to me.

This release of information will remain in effect until terminated by me in writing.

By signing below I am confirming that I am the patient, legal guardian, or POA of the above named patient.

Printed Name and Signature: Date: