BLACK MOUNTAIN FAMILY MEDICINE

PATIENT INFORMATION

Last	First	Middle	DOB
			— —

Address	City	State	Zip

Home Phone	Soc. Sec. #	Sex	Marital Status
( )	— —	☐ M ☐ F	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Age	Race	E-mail Address	Primary Physician
	☐ Amer. Indian ☐ Asian Pacific Island ☐ Black ☐ Caucasian ☐ Hispanic ☐ Other ☐ Refused ☐ Unknown		

Employer	Employer - Address, City/State/Zip	Wk. Phone
		( )

GUARANTOR INFORMATION

Last	First	Middle	DOB
			— —

Address	City	State	Zip

Home Phone	Soc. Sec. #	Relation to Pt.	Black Mountain Fam. Medicine Pt.
( )	— —		☐ Y ☐ N

Employer	Employer - Address, City/State/Zip	Wk. Phone
		( )

Marital Status	
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	

INSURANCE INFORMATION

Primary Insurance - Network	Plan Address City/State/Zip
#1	

Insurance Phone	I.D./Policy #	Group/Plan #	Plan Type
( )			HMO PPO Other:

Effective Date	Subscriber/Policyholder's Name	Sub's DOB

Relation to Pt.	Sub's Employer	Co-Pay

Secondary Insurance - Network	Plan Address City/State/Zip
#2	

Insurance Phone	I.D./Policy #	Group/Plan #	Plan Type
( )			HMO PPO Other:

Effective Date	Subscriber/Policyholder's Name	Sub's DOB

Relation to Pt.	Sub's Employer	Co-Pay

FAMILY / OTHER INFORMATION

Emergency Contact	Relation to Pt.	Home Phone	Wk. Phone
		( )	( )

Address	City	State	Zip

Other Family Member	Relation to Pt.	DOB

Other Family Member	Relation to Pt.	DOB

Other Family Member	Relation to Pt.	DOB

Other Family Member	Relation to Pt.	DOB

Referred By:	Release Test Results To:	Relation to Pt.

I hereby authorize payment directly to Black Mountain Family Medicine for surgical and/or medical benefits, if any, otherwise paid to me for unpaid services rendered and the release of any information necessary to process claims for said services and authorization to release records pertaining to my treatment to my insurance company or other 3rd parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan, via voice, electronic, mail or fax transmission. I also agree to pay all charges and/or co-payment at the time of service. In the event of default, I promise to pay all legal fees, collection costs, and/or interest as may be required to effect collection of this note. This will also serve as an authorization for release of emergency department urgent care and/or medical records which may be necessary to my medical care.

Signed: ______________________________ Date: ______________

(Patient or Responsible Party)