Patient Registration *(please print clearly)*

Last Name: ______________________ First: ______________ Middle: ____________

Preferred Name: ____________________ Date of Birth: __________ Birth Sex: ☐ Male ☐ Female

SSN: ____________ Driver License #: ____________ Preferred Language: ____________

I identify as: ☐ Female ☐ Female-to-Male Transgender ☐ Non-Conforming
☐ Male ☐ Male-to-Female Transgender
☐ Other: ______________________________ ☐ Decline to answer

Race: ☐ Asian ☐ American Indian or Alaska Native ☐ African American
☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Decline to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer

Marital Status: ☐ Single ☐ Married ☐ Divorced

Home Address: ______________________ City: ____________ State: ______ Zip: ______

Mailing Address: ______________________ City: ____________ State: ______ Zip: ______

Primary Phone: ______________ ☐ Home ☐ Work ☐ Cell Email: __________________

Secondary Phone: ______________ ☐ Home ☐ Work ☐ Cell

Preferred Pharmacy: __________________ Appointment Reminders OK? ☐ Yes ☐ No

Ok to leave message on: Home? ☐ Yes ☐ No Work? ☐ Yes ☐ No Cell? ☐ Yes ☐ No

Emergency Contact: __________________ Phone: ____________ Relationship: __________

Emergency Contact: __________________ Phone: ____________ Relationship: __________

Employer: ________________________ Phone: ____________ Occupation: __________

PRIMARY INSURANCE INFORMATION

Policy Holder: ______________ DOB: __________ SSN: __________ Relationship: __________

Primary Insurance: __________________ Policy #: ____________ Group #: ____________

SECONDARY INSURANCE INFORMATION

Policy Holder: ______________ DOB: __________ SSN: __________ Relationship: __________

Secondary Insurance: ________________ Policy #: ____________ Group #: ____________

I authorize treatment of the person named above and accept financial responsibility for all treatment provided. I authorize Mountainview to provide my insurance companies with all information necessary to process insurance claims and assign payments to Mountainview all of the insurance benefits due to me to the full extent of my financial obligation. A photocopy of this authorization shall be considered as valid as the original. I have read and understood all of the above.

Signature: ____ Date: ______________

A part of

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