Mountain Medical Center

Please complete ALL sections below.

Date_____

PATIENT INFORMATION

Last_____ First_____ Middle_____ Preferred Name_____

Date of Birth_____/_____/_____ Social Security Number_____-_____-_____

Mailing Address_____ Physical Address_____

City_____ State_____ Zip Code_____

Home Phone_____ Work Phone_____ Cell Phone_____

Email Address (used for patient portal access)_____

INSURANCE INFORMATION: Insurance Company Name or self pay? _____

Policy # _____ Group # _____ Co-Pay Amt _____

Date of Birth of Subscriber (Name on Your Insurance Card): ____/____/_____ (we MUST have this for billing purposes)

GUARANTOR INFORMATION (FINANCIALLY RESPONSIBLE INDIVIDUAL) □ check if same as patient

Last_____ First_____ Middle_____ Preferred Name_____

Date of Birth_____/_____/_____ Social Security Number_____-_____-_____

Mailing Address_____ Physical Address_____

City_____ State_____ Zip Code_____

Home Phone_____ Work Phone_____ Cell Phone_____

EMERGENCY CONTACT OR NEXT OF KIN: Name_____

Relationship to you_____Address_____ Phone # _____

Who Is Your Usual Provider? □ Joel Gates, DO □ Suzanne Haag, PA-C
Marital Status: □ Single □ Married □ Divorced □ Widowed
Sex: □ Male □ Female
Race: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White □ Undisclosed
Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino
Preferred Language: □ English □ Spanish □ Other_____
Do you have any visual or hearing needs, preferences, or limitations? □ Yes □ No □ Explain_____
Patient or Guarantor's Occupation _____
Do you have a legal guardian / health care proxy? □ Yes (Name_____) □ No
Do you have a primary caregiver? □ Yes (Name_____) □ No
Do you have advance directives? □ Yes (Please give a copy to your nurse or provider) □ No
Do you give your consent to access your medical records though an online, secured patient portal? □ Yes □ No
Would you like to receive our digital newsletter? □ Yes □ No