REGISTRATION FORM
THIS INFORMATION
IS CONFIDENTIAL

CAREMOUNT MEDICAL
caremountmedical.com

PATIENT

FIRST-MIDDLE-LAST NAME		BIRTH DATE	CMM USE ONLY-ACCOUNT #
STREET ADDRESS (APT #) CITY, STATE		ZIP CODE	MARITAL STATUS / SEX
EMAIL ADDRESS	RACE		SOCIAL SECURITY#
HOME # / CELL#	WORK#		RELATIONSHIP TO RESPONSIBLE PARTY
PRIMARY CARE PHYSICIAN	EMERGENCY CONTACT		EMERGENCY CONTACT PHONE#
RELATION TO EMERGENCY CONTACT	PHARMACY		AREA CODE- PHARMACY PHONE #
EMPLOYER NAME & ADDRESS		EMPLOYER PHONE#	

RESPONSIBLE

PERSON RESPONSIBLE FOR PAYMENT IF PATIENT IS UNDER AGE 18			
FIRST-MIDDLE-LAST NAME (PERSON RESPONSIBLE FOR PAYMENT IF PATIENT UNDER AGE 18)			TITLE / SEX
STREET ADDRESS (APT #) CITY, STATE			ZIP CODE
AREA CODE-HOME PHONE #	BIRTH DATE	SOCIAL SECURITY #	
EMPLOYER NAME & ADDRESS		EMPLOYER PHONE #	

INSURANCE INFO

PRIMARY COVERAGE			
INSURANCE COMPANY NAME		EFFECTIVE DATE	ID #
GROUP NUMBER	SUBSCRIBER NAME (NAME OF PERSON THAT HOLDS THE INSURANCE)		
SUBSCRIBER BIRTH DATE	SUBSCRIBER EMPLOYER	PT RELATIONSHIP TO SUBSCRIBER	SOCIAL SECURITY #
STREET ADDRESS TO SEND CLAIM CITY, STATE, ZIP CODE			INSURANCE COMPANY PHONE #
SECONDARY COVERAGE			
INSURANCE COMPANY NAME		EFFECTIVE DATE	ID #
GROUP NUMBER	SUBSCRIBER NAME (NAME OF PERSON THAT HOLDS THE INSURANCE)		
SUBSCRIBER BIRTH DATE	SUBSCRIBER EMPLOYER	PT RELATIONSHIP TO SUBSCRIBER	SOCIAL SECURITY #
STREET ADDRESS TO SEND CLAIM CITY, STATE, ZIP CODE			INSURANCE COMPANY PHONE #

RELEASE

I hereby authorize CareMount Medical for any provider having treated me or my dependent, to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment and for quality assurance purposes. I authorize payment of medical benefits directly to CareMount Medical. I understand I am financially responsible for any balance not covered by my insurance carrier.

Signed : _____ Date: _____
(Patient, or parent of minor)

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