

REGISTRATION FORM
THIS INFORMATION
IS CONFIDENTIAL



P A T I E N T	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#		
R E S P O N S I B L E	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 #		
I N S U R A N C E I N F O	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 #		
R E L E A S E	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 : _____ (Patient, or parent of minor)			Date: _____		031618mw