# PATIENT REGISTRATION FORM

| Patient Information | | |
|---|---|---|
| Last Name: | First Name: | M.I. |
| Mailing Address: | | |
| City: | State: | Zip: |
| Home Phone: | Cell Phone: | |
| Preferred Method of Contact for Reminder Calls: | Please circle one:<br>*Voice* *Text* | |
| Date of Birth: | Sex:<br>*Male* *Female* | |
| Email: | | |
| Marital Status: | | |
| Emergency Contact Name: | Emergency Contact Phone #: | Relationship: |

| Responsible Party (If the patient is under 18) | | |
|---|---|---|
| Last Name: | First Name: | M.I. |
| Date of Birth: | | |
| Relationship to the patient: | | |

| Primary Medical Insurance | Secondary Medical Insurance |
|---|---|
| Ins. Co. Name: | Ins. Co. Name: |
| Policy Holder Name: | Policy Holder Name: |
| Policy Holder Date of Birth: | Policy Holder Date of Birth: |

**No-Show Policy:** If you miss an appointment and DO NOT cancel it within 24 hrs you will be changed a no-show fee.
**Copay-Deductible Policy:** If your insurance requires a co-payment, it is expected at check-in. If your insurance plan has a deducible you will be expected to make a down payment of $60 before you will be seen.

I nearby consent to authorize the administration and performance of all treatments and operations which in the judgement of the attending physician may be considered necessary or advisable.

I authorize Coalville & Kamas Health Centers to release necessary medical information to my insurance company or other agents preparing my clinic or hospital claim.

Patient Signature:_______________________________________________Date:__________________

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