Please review and update the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION -- PLEASE PRINT

Last Name:
First Name:
Middle Name:
Address:
City: State:
Zip:
Home Phone:
Work Phone:
Mobile Phone:
Sex:
Date of Birth:
Social Security No.:
Patient email:

Required by government mandate [although you may refuse]:

Language:
Race:
Ethnicity:
Marital Status:

Guarantor Information (to whom statements are sent)

Name:
Address:
,
Relationship to patient: _____
Date of Birth:
Social Security No.:
Phone: ( ) _____ - _____

Emergency Contact Information

Name:
Relationship:
Phone:
Mobile Phone:( ) _____ - _____

Employer information

Employer:
Address:
Phone:

Other

Patient Referred by:

Primary Care Provider:

Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email

Pharmacy Information:

Name:

Crossroads:

Phone:

Primary Insurance Information

Insurance Plan Name:
Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): **M** or **F**
Employer Name:
Patient's relationship to policy holder:

Secondary Insurance Information

Insurance Plan Name:
Last Name:
First Name.:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): **M** or **F**
Employer Name:
Patient's relationship to policy holder:

To the best of my knowledge the above information is complete and accurate.

Signed_____ **Date:**_____

Please sign and date each item below

ACKNOWLEDGEMENT AND AUTHORIZATION:

- **I have read and understand the HIPAA/Privacy Policy for BOUNTIFUL INTERNAL MEDICINE**

Signed_____ **Date:**_____

- **I hereby assign my insurance benefits to be paid directly to the healthcare provider**

Signed_____ **Date:**_____

- **I authorize BOUNTIFUL INTERNAL MEDICINE to release medical information required to process my claim**

Signed_____ **Date:**_____

- **I have read and understand the Financial Policy for BOUNTIFUL INTERNAL MEDICINE**

Signed_____ **Date:**_____

- **I authorize BOUNTIFUL INTERNAL MEDICINE to obtain/have access to my medication history**

Signed_____ **Date:**_____

- **I authorize my provider's office to contact me by mobile phone**

Signed_____ **Date:**_____