MILE HIGH FAMILY MEDICINE
REGISTRATION FORM
(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Email:	Pharmacy(name and cross street):	Primary Language:

Due to our use of Electric Medical Records, we are required to have the most up-to-date information for our patients. We request your help in obtaining some additional information to complete your chart. **Please circle the closest choice:**

Native American White Native Hawaiian African American Other Polynesian More than 1 race Asian

Unknown Hispanic

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Mile High Family Medicine or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*