Mountain View Gastroenterology, PC
Patient Registration

Patient Information
Patient Name (Last) _____ (First) _____ (Middle Initial) _____
Date of Birth: ____/____/____ SSN: _____-_____-_____ Sex: □Male □Female

**Mailing address _____ (City/ST/Zip) _____
Physical address _____ (City/ST/Zip) _____
Home#_____ Cell# _____ WK# _____EXT. ____
Primary contact# (list HM or Cell, etc.)_____

Marital Status: □Married □Single □Divorced □Widow
Spouse Name: _____ SSN: _____-_____-_____ Spouse's Date of Birth: ____/_____/_____
Spouse's Employer_____ WK# _____

In case of emergency notify:
Name: _____ Phone# _____ Relationship to patient: _____

Responsible Party Information (if Different than above):
Name: _____ SSN: ____/____/____ Date of Birth: ____/___/____
Address: _____ (City/ST/Zip) _____
Phone# _____

Relationship to Patient: _____

Primary Insurance:
Name of Insurance Co. _____Name of Policy Holder: _____
Insurance Address: _____ (City/ST/Zip) _____
ID/Policy# _____ Group# _____

Secondary Insurance: (if applicable)
Name of Insurance Co. _____ Name of Policy Holder: _____
Insurance Address: _____ (City/ST/Zip) _____
ID/Policy# _____ Group# _____

1.) I understand, by signing, the information above is complete and accurate. I am required by law to notify this office if any insurance changes, wither it has changed or terminated.
2.) I understand that I am responsible for charges not covered by the above agents. I agree, in the event of non-payment, to assume the cost of interest, collection, and legal action (if required).
3.) I authorize my insurance carrier to release information regarding my coverage to Mountain View Gastroenterology.
4.) I acknowledge this document as a legally binding assignment to collect my benefits as payments of claims services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me, I will endorse such payments to Mountain View Gastroenterology.

Patient Signature: _____ Date: _____/_____/_____