HIGH MOUNTAIN HEALTH, P.A.
Patient Registration Form

REFERRED BY:_____

NAME:_____ **S.S. NUMBER**_____

ADDRESS:_____ **DATE OF BIRTH**_____

CITY/STATE:_____**ZIP**:_____ **HOME PHONE**_____

PARENT/GUARDIAN:_____ **CELL PHONE:**_____

GENDER___ **MALE** ___ **FEMALE** **MARITAL STATUS** _____

EMPLOYER NAME: _____**Phone #** _____
Emp. Address:_____**City/State**_____
Patients Occupation:_____

PRIMARY INSURANCE_____
ID# _____ **Group#** _____
INSURED'S NAME: _____ **RELATION TO PATIENT**_____
SUBCRIBER'S EMPLOYER;_____

SECONDARY INSURER:_____
INSURED'S NAME:_____ **RELATION TO PATIENT**_____
SUBSCRIBER'S EMPLOYER:_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS
I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

I hereby authorize High Mountain Health, PA, to apply for benefits on my behalf for covered services rendered by my family physician or by his/her order. I request that payment form my insurance company be made directly to High Mountain Health, PA (or to the party who accepts assignment),

I certify that the information I have reported with regard to my insurance coverage is correct.

I agree and accept the terms of the High Mountain Health's Financial Policy.

I permit a copy of this authorization to be used in place of the original. This authorization by be revoked by either me or my insurance company at any time in writing,

Date: _____ **Signature** (Patient/Guardian)_____

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