Intermountain Medical Group

(TO BE COMPLETED BY FACILITY)

MEDICAL RECORD NUMBER: _____

PATIENT INFORMATION

PATIENT INFORMATION

Today's Date: ____ / ____ / ____ (MONTH / DAY / YEAR)

Legal Name: _____ (LAST NAME / FIRST NAME / MIDDLE NAME)

Maiden / AKA / Preferred Name: _____ (OTHER NAME USED BY PATIENT / LAST NAME / FIRST NAME / MIDDLE NAME)

Address: _____

City: _____ State: _____ Zip: _____ Home Telephone: (____) ____ — ____ (AREA CODE)

Cell Telephone: _____ Preferred Contact Telephone: _____

Sex: ☐ M ☐ F Date of Birth: ____ / ____ / ____ (MONTH / DAY / YEAR) Social Security Number: ____ — ____ — ____

Marital Status ☐ Single (S) ☐ Married (M) ☐ Widowed (W) ☐ Separated (SE) ☐ Divorced: (D)

Primary Care Physician (PCP): _____ Referring Physician: (IF DIFFERENT FROM PCP) _____

Employer: _____ Work Telephone: (____) ____ — ____ (AREA CODE)

Address: _____ City: _____ State: _____ Zip: _____

Person to contact in an Emergency: _____ (NOT AT PATIENT'S ADDRESS / LAST NAME / FIRST NAME) Emergency Telephone: (____) ____ — ____ (AREA CODE)

Relationship: _____

GUARANTOR INFORMATION

GUARANTOR INFORMATION — PERSON TO RECEIVE THE PATIENT'S BILL **(COMPLETE INFORMATION ONLY IF DIFFERENT FROM PATIENT)**

Legal Name: _____ (LAST NAME / FIRST NAME / MIDDLE NAME)

Relationship of Patient to the Guarantor: ☐ Dependent Child (DEP) ☐ Spouse (SPO) ☐ Student (STU) ☐ Other (OTH) _____

Other / Maiden / AKA Name: _____ (OTHER NAME USED BY PATIENT / LAST NAME / FIRST NAME / MIDDLE NAME)

Address: _____

City: _____ State: _____ Zip: _____ Home Telephone: (____) ____ — ____ (AREA CODE)

Cell Telephone: _____ Preferred Contact Telephone: _____

Sex: ☐ M ☐ F Date of Birth: ____ / ____ / ____ (MONTH / DAY / YEAR) Social Security Number: ____ — ____ — ____

Marital Status ☐ Single (S) ☐ Married (M) ☐ Widowed (W) ☐ Separated (SE) ☐ Divorced: (D)

Employer: _____ Work Telephone: (____) ____ — ____ (AREA CODE)

Address: _____ City: _____ State: _____ Zip: _____

HEALTH CARE COVERAGE

PRIMARY HEALTH CARE COVERAGE (INSURANCE) NAME: _____ (NAME OF INSURANCE)

Ins. Mailing Address: _____ City: _____ State: _____ Zip: _____

Ins. Telephone: (____) ____ — ____ (AREA CODE) Effective Date of Coverage: ____ / ____ / ____ (MONTH / DAY / YEAR) OFFICE VISIT COPAY:$ _____

Instacare Copay: $ _____ Specialty Copay: $ _____ Behavioral Health Copay: $ _____

Policy or ID (Cert.) No.: _____ Group No.: _____ Plan Name or No.: _____

Relationship of Patient to Subscriber (Policy Holder): ☐ Self (SEL) ☐ Dependent Child (DEP) ☐ Spouse (SPO) ☐ Student (STU)

☐ Other (OTH) : _____

Complete Subscriber (Policy Holder) information below ONLY if different from Patient

Subscriber's Name: _____ (LAST NAME / FIRST NAME / MIDDLE NAME)

Subscriber's Address: _____

City: _____ State: _____ Zip: _____ Subscriber's Telephone: (____) ____ — ____ (AREA CODE)

Sex: ☐ M ☐ F Date of Birth: ____ / ____ / ____ (MONTH / DAY / YEAR) Social Security Number: ____ — ____ — ____

Subscriber's Employer: _____

SEE OTHER SIDE

ADDITIONAL HEALTH CARE COVERAGE

SECONDARY HEALTH CARE COVERAGE (INSURANCE) NAME: _____
(NAME OF INSURANCE)

Ins. Mailing Address: _____ City: _____ State: _____ Zip: _____

Ins. Telephone: (_____) _____ — _____ Effective Date of Coverage: _____ / _____ / _____ OFFICE VISIT COPAY:$ _____
AREA CODE — MONTH / DAY / YEAR

Policy or ID (Cert.) No.: _____ Group No.: _____ Plan Name or No.: _____

Relationship of Patient to Subscriber (Policy Holder): ☐ Self (SEL) ☐ Dependent Child (DEP) ☐ Spouse (SPO) ☐ Student (STU)
☐ Other (OTH) : _____

Complete Subscriber (Policy Holder) information below ONLY if different from Patient

Subscriber's Name: _____
LAST NAME — FIRST NAME — MIDDLE NAME

Subscriber's Address: _____

City: _____ State: _____ Zip: _____ Subscriber's Telephone: (_____) _____ — _____
AREA CODE

Sex: ☐ M ☐ F Date of Birth: _____ / _____ / _____ Social Security Number: _____ — _____ — _____
MONTH / DAY / YEAR

Subscriber's Employer: _____

ADDITIONAL HEALTH CARE COVERAGE (INSURANCE) NAME: _____
(NAME OF INSURANCE)

Ins. Mailing Address: _____ City: _____ State: _____ Zip: _____

Ins. Telephone: (_____) _____ — _____ Effective Date of Coverage: _____ / _____ / _____ OFFICE VISIT COPAY:$ _____
AREA CODE — MONTH / DAY / YEAR

Policy or ID (Cert.) No.: _____ Group No.: _____ Plan Name or No.: _____

Relationship of Patient to Subscriber (Policy Holder): ☐ Self (SEL) ☐ Dependent Child (DEP) ☐ Spouse (SPO) ☐ Student (STU)
☐ Other (OTH) _____

Complete Subscriber (Policy Holder) information below ONLY if different from Patient

Subscriber's Name: _____
LAST NAME — FIRST NAME — MIDDLE NAME

Subscriber's Address: _____

City: _____ State: _____ Zip: _____ Subscriber's Telephone: (_____) _____ — _____
AREA CODE

Sex: ☐ M ☐ F Date of Birth: _____ / _____ / _____ Social Security Number: _____ — _____ — _____
MONTH / DAY / YEAR

Subscriber's Employer: _____

DEPENDENT INFORMATION

DEPENDENT INFORMATION Please list any additional family members who live at the same address and have the same insurance as the patient, and will also be seeing a health care provider in this office.

NAME (LAST NAME, FIRST NAME, MIDDLE NAME)	SEX	DATE OF BIRTH (MONTH / DAY / YEAR)	SOCIAL SECURITY #	NAME OF INSURANCE CO.
	☐ M ☐ F	/ /		
	☐ M ☐ F	/ /		
	☐ M ☐ F	/ /		
	☐ M ☐ F	/ /		
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