Copper Mountain Clinic

2175 W 16th Street – Ste D -Safford-AZ-88546
Phone 928-348-1600 / Fax 844-271-2379

ADULT PATIENT REGISTRATION FORM

Legal Name (Last) ________________________________(First) _________________________ (MI)________

Date of Birth: _________________________ Social Security#: _______________________

Gender: M F Marital Status: S M D W

Mailing Address: ______________________________________ City: _____________ State: ______ Zip: _______

Street Address (if different than above): ____

Home Phone#: __________________ Work Phone#: ____________________ Cell Phone#: ___________________

E-Mail Address: ____

Employer: ____ Occupation: _______________________________

If Applicable-

Referred by: __________________________________ **Primary Care Physician:** _____________________________

Ethnicity & Race: ☐Hispanic/Latino ☐America/Indian/Alaska Native ☐Asian ☐Black/African American

☐ Native Hawaiian/Other Pacific Islander ☐White ☐Other Race ______________________

Preferred Language: _______________________

How would you like to be contacted with confidential information?

☐ Home Phone ☐ Cell ☐ Email ☐ Letter ☐ Patient Portal ☐ Other: _________________________

Spouse Information:

Name of Spouse: ____ Date of Birth: _________________

Social Security#: ______________________ Phone#: __________________________

Spouse's Employer: ____

Emergency Contact:

Name: ____________________________________ Relationship: ________________Phone#: ________________

Name: ____________________________________ Relationship: ________________Phone#: ________________

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Release of Information to Others

I authorized Mt. Graham Regional Medical Center / Copper Mountain Clinic to discuss my health condition with the following individuals (**MUST** list the names of family or friends):

Name: ________________________________ Relationship: ______________ Phone#: ______________

Name: ________________________________ Relationship: ______________ Phone#: ______________

Insurance Information (must be completed in full in additional to providing a copy of actual insurance card)

Primary Insurance-

Company: ___________________________ ID#____________________ Group#__________________

Policy Holder's Relationship to Patient: ☐ Self ☐ Spouse ☐ Dependent

Policy Holder's Name: ____

Date of Birth: ______________________ Policy Holder's Social Security #: _________________

Policy Holder's Address: ____

Secondary Insurance-

Company: ___________________________ ID#____________________ Group#__________________

Policy Holder's Relationship to Patient: ☐ Self ☐ Spouse ☐ Dependent

Policy Holder's Name: ____

Date of Birth: ______________________ Policy Holder's Social Security #: _________________

Policy Holder's Address: ____

Acknowledgement

The above information is true to the best of my knowledge. I authorize insurance benefits to be paid directly to MGRMC and I understand that I am financially responsible for any self-pay/co-insurance/deductible amounts. If this account should be sent to collections, I agree to pay collection expenses. I also authorized MGRMC or the insurance company to release any information required to process my claim(s). I authorize a copy of this authorization to be used in place of the original authorize MGRMC to apply for benefits on my behalf for covered services rendered by any provider within the or by their order. I authorized MGRMC to obtain my medication history.

Signature: ____ Date: ____________________________
Patient/Parent/Guardian