Copper Mountain Clinic
2175 W 16th Street- Ste D - Safford-AZ-85546
Phone 928-348-1600 / Fax 844-271-2379

Child Registration Form

Legal Name (Last) _____ (First) _____ (MI) _____

Gender: M F Date of Birth: _____ Social Security#:_____

Phone Number: _____ Person of Contact When Calling _____

Mailing Address: _____ City: _____

State: _____ Zip: _____

Student: ☐ Yes ☐ No

Ethnicity & Race: ☐ Hispanic/Latino ☐ America/Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other Race

Preferred Language: _____

Mother's Information/Legal Guardian

Name (Last) _____ (First) _____

Date of Birth: _____ Social Security#:_____

Mailing Address: _____ City: _____

State: _____ Zip: _____

Home Phone#:_____ Work Phone#:_____ Cell Phone#:_____

Employer: _____Occupation:_____

Father's Information/Legal Guardian

Name (Last) _____ (First) _____

Date of Birth: _____ Social Security#:_____

Mailing Address: _____ City: _____

State: _____ Zip: _____

Home Phone#:_____ Work Phone#:_____ Cell Phone#:_____

Employer: _____Occupation:_____

How would you like to be contacted with confidential information?
☐ Home ☐ Cell ☐ Email ☐ Letter ☐ Patient Portal ☐ Other: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone#:_____

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Name: _____ Relationship: _____ Phone#:_____

Release of Information to Others:

I authorized Mt. Graham Regional Medical / 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 Name & Date of Birth: _____ Policy Holder's Social Security #:_____

Policy Holder's Address: _____ Policy Holder's Relationship to Patient: _____

Secondary Insurance Company: _____ID#_____Group#_____

Policy Holder's Name & Date of Birth: _____ Policy Holder's Social Security #:_____

Policy Holder's Address: _____ Policy Holder's Relationship to Patient: _____

Notarized Legal Guardian Consent Form-

This form gives written and notarized permission from the legal parent/guardian to an individual who is listed and notarized on the form, to bring listed minor into Copper Mountain Clinic for appointments and to make limited health care decisions in regards to the minor patient. If there is not a signed and notarized form filed in the minor patients chart, no one but a parent/legal guardian may bring a minor in for treatment. Notary services are offered at the Mount Graham Regional Medical Center Medical Records Office free of charge for medical purposes.

Form Offered: _____ Form Declined: _____ Form Returned: _____

Signature: _____ Date: _____
Patient/Parent/Guardian

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