Rocky Mountain Allergy, Asthma, and Immunology, LLC

PLEASE FILL OUT EVERY SPACE. IF IT DOES NOT PERTAIN TO YOU, PLEASE WRITE N/A FOR NOT APPLICABLE

PATIENT INFORMATION

Last Name	First Name	Middle Initial	Gender **M F**	DOB / /

Mailing Address	City	State	Zip

Home Phone #	Cell Phone #	Work Phone #	Social Sec. #

Employer Name & Address	Email Address

Marital Status	Spouse's Name	Spouse's DOB / /	Spouse's Phone#

Race
☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Ethnicity – *Race/Ethnicity Questions are asked in order to identify additional care needs of our diverse patients. No Discrimination Intended*
☐ Caucasian ☐ Hispanic ☐ African American ☐ Pacific Islander ☐ American Indian/Alaska Native ☐ Asian

How Did You Hear About Our Practice?
☐ Facebook ☐ Good 4 Utah ☐ Health Fair ☐ Insurance ☐ Internet Search ☐ KUTV ☐ Ogden Marathon ☐ Radio ☐ Seminar ☐ Twitter
☐ Another Patient (Name): _____ ☐ Other: _____

☐ Referring Provider: Provider Name _____ Provider Ph# _____ Facility _____

RESPONSIBLE PARTY INFORMATION

☐ Mother ☐ Father ☐ Self ☐ Other _____	Last Name (If Not Patient)	First Name	DOB / /	Gender **M F**

Address	City	State	Zip

Primary Phone #	Social Sec. #	Employer	Business Phone #

PARENT / GUARDIAN INFORMATION (FILL OUT IF PATIENT IS UNDER 18 YRS OF AGE)

☐Mother ☐Father ☐Other: _____	First & Last Name	Phone Number

☐Mother ☐Father ☐Other: _____	First & Last Name	Phone Number

INSURANCE INFORMATION

Primary Insurance: Name & Address		ID #	Group #

Policy Holder Name	Policy Holder DOB / /	Social Security #	Effective Date / /

Policy Holder Address	Policy Holder Phone #	Relationship to Patient ☐Self ☐Spouse ☐Parent ☐Other____

Secondary Insurance: Name &Address		ID #	Group #

Policy Holder Name	Policy Holder DOB / /	Social Security #	Effective Date / /

Policy Holder Address	Policy Holder Phone #	Relationship to Patient ☐Self ☐Spouse ☐Parent ☐Other____

EMERGENCY CONTACT

First & Last Name	Phone Number	Relationship to Patient

If this visit is due to an accident, please provide the information here. ☐ Auto ☐ Industrial
Details:

Consent to Treat and to Disclose Protected Health Information: I authorize the physician or physicians in charge of the care of the above named patient to administer anesthetics and/or medications and to perform such operations and/or diagnostic procedures as may be deemed necessary by the physician for the diagnosis and treatment of this patient.
The practice's Written Privacy Notice provides detailed information on how we may use and disclose protected health information. By signing this consent form, you acknowledge that you have received a copy of the Written Privacy Notice and are in agreement with our use and disclosure of protected health information for treatment, payment, and health care operations. Patients injured at work typically obtain information through their adjuster or employer. I have read and understand the above statements. Affixing my signature to this form represents my receipt of the Written Privacy notice, my consent to treatment, and the above listed uses of protected health information.

_____ _____

Signature of Patient / Responsible Party Date