MOUNTAIN UTAH FAMILY MEDICINE, P.C.
879 N. Main, Richfield, Utah 84701 • (435) 896-9561

PATIENT INFORMATION:

Date:_____ Birth Date:_____ Marital Status:_____ Sex:_____

Patient's Name:_____ Birth/Maiden Name:_____
First Middle Initial Last

Home Phone:_____ Cell:_____ Work:_____

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

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

Social Security #: _____ Place Of Employment:_____

Email: _____ Drivers License #:_____Exp. Date:_____State:_____

Preferred method of contact: ❑ Cell Phone ❑ Home Phone ❑ Work Phone ❑ Email

Race: Please check one

❑ American Indian or Alaska Native ❑ Asia ❑ Black or African American ❑ Native Hawaii or Other Pacific Islander

❑ White ❑ Other Race ❑ Decline Ethnic Group_____ Language_____

EMERGENCY CONTACT:

Name:_____ Relationship:_____ Phone:_____

May we leave this type of information on your answering machine?_____

RESPONSIBLE PARTY: *(If other than self)*

Responsible Party Name:_____ Phone:_____

Address:_____

Birth Date:_____ Social Security #:_____ Relationship to Patient:_____

Employer:_____ Work Phone:_____ Work Address:_____

INSURANCE INFORMATION:

Primary Insurance:
In Whose Name Is The Policy Carried:_____ Birthdate:_____

Social Security #:_____

Insurance Company:_____ Phone:_____ Eff. Date:_____

I.D. #: _____ Group #:_____

Secondary Insurance:
In Whose Name Is The Policy Carried:_____ Birthdate:_____

Social Security #:_____

Insurance Company:_____ Phone:_____ Eff. Date:_____

I.D. #: _____ Group #:_____