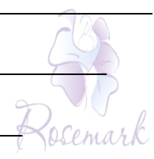
Patient Information **Preferred Pharmacy**______________________________



Last Name: __________________________First Name:__________________________ Middle Name: __________________

Preferred Name: ________________________________Maiden Name: _______________________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated SS#:____________________________

Date of Birth: _____________________ **Sex:** ☐ **Female** ☐ **Male**

Race:

- ☐ **America Indian/Alaska Native**
- ☐ **Asian**
- ☐ **Nat. Hawaiian/Pacific Islander**
- ☐ **White**
- ☐ **Black/African American**
- ☐ **Other Race**
- ☐ **Declined**

Ethnicity:

- ☐ **Non Hispanic or Latino** ☐ **Declined**
- ☐ **Hispanic or Latino**

Preferred Communication:

☐ **Fax** ☐ **Email** ☐ **Mail** ☐ **Phone** ☐ **Declined**

Primary Language: ____________________________ **Email:**____

Address:____________________________________City/ State/ Zip/County: _______________________________

Home Phone: ( ) _______ - ________________ Cell Phone: ( ) _______ - ________________________________

Work Phone: ( ) ______ - _________________ Primary Phone: ( ) _______-_____________________________

Employer: ____

Emergency Contact:___________________________Phone: ( ) _______ - _______________ Relationship: ______________

Financially Responsible Party or Guardian: ____

Whom can we thank for referring you to our practice? ☐ Radio ☐ Newspaper ☐ Friend/Family (Name)___________________ ☐ Other________________________

Spouse or Guardian Information:

Name: _________________________ Relationship to Patient:_________________ SS#:_______________________

Date of Birth: ____________________ Employer: ___________________ Work phone: __________________________

Primary Insurance: Please provide the following information for the policy holder of your insurance:

Insurance Company: ______________________________ID #_____________________Group #__________________

Policy Holder Name: _________________________Policy Holder Date of Birth: _______________________________

Secondary Insurance: Please provide the following information for the policy holder of your insurance:

Insurance Company: ______________________________ID #_____________________Group #__________________

Policy Holder Name: _________________________Policy Holder Date of Birth: _______________________________

Please provide a copy of all Insurance Cards.

Ownership Disclosure: Dr. Jeffrey Baker, Dr. Ty Erickson and Dr. Barbara Nelson have individual ownership interest in Mountain View Hospital and may refer you there for services. If you prefer to receive care or testing at another hospital or facility, please inform your treating provider. _________ **Acknowledgement Initial**

Signature of patient or responsible party: ___________________________________ Date: __________________________

Updated 2/8/2012