MOUNTAIN VIEW SURGERY CENTER
PATIENT REGISTRATION SHEET

DATE: _____ PRIMARY LANGUAGE: _____

NAME: _____ DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ E-MAIL: _____

AGE: _____ MALE _____ FEMALE _____ EMPLOYER: _____

PHONE NUMBERS: Home; _____ ( ) OK to leave detailed message

Cell; _____ ( ) OK to leave detailed message

Work; _____ ( ) OK to leave detailed message

Race: (check one)

- ☐American Indian
- ☐Alaskan Native
- ☐Asian
- ☐Black
- ☐African American
- ☐Native Hawaiian
- ☐Other Pacific Islander
- ☐White
- ☐Other Race
- ☐Unknown

Ethnicity: (check one)

- ☐Hispanic
- ☐Non-Hispanic
- ☐Other

INSURANCE INFORMATION:

Name of Insured/Responsible Party: _____

Name of Insurance: _____

Policy/ID Number: _____

EMERGENCY CONTACT INFORMATION:

Emergency Contact Person: _____

Relationship to Patient: _____

Contact Person Home Phone #: (____) _____ Cell Phone #: (____) _____

REFERRING PHYSICIAN OR PRIMARY PHYSICIAN INFORMATION:

Referring Physician Name: _____

Address: _____ City _____ Zip _____

Office Phone # (____) _____ Fax Number (____) _____

**Please remember to bring your photo ID, Insurance cards, and a driver must accompany you to your appointment.*

**Please be aware that you may be held responsible for any and all collection fees if your account becomes delinquent.*

Patient Signature: _____ Date: _____

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