PATIENT REGISTRATION

Patient Information

*Name (first, MI, last):	*SSN:	*Today's Date:
*Address:	*City, State, Zip:	
*Home phone:	Mobile phone:	Work phone:
Age:	*Birth date:	*Gender:

Race:
- o American Indian or Alaska Native
- o Asian
- o Native Hawaiian
- o Black or African American
- o White
- o Hispanic
- o Other Pacific Islander
- o Other Race

Ethnicity:
- o Hispanic
- o Non-Hispanic

Preferred Language:_____

Marital Status:

Patient Employer/School:

Address:	City, State, Zip:

Responsible Party (if other than patient)

Name (first, MI, last):		SSN:
Address:	City, State, Zip:	
Home phone:	Mobile phone:	Work phone:
Employer:		Work Fax:
Employer Address:	City, State, Zip:	

*required

Insurance Information

We must have a current copy of your insurance card(s) in order to file your insurance for you. If we do not have this information, you will be responsible for your total bill.

Primary	Primary Insurance Company:		Card provided for scanning ☐
	Insured's Name:	Birth date:	Relation to Patient:
Secondary	Secondary Insurance Company:		Card provided for scanning ☐
	Insured's Name:	Birth date:	Relation to Patient:
Tertiary	Tertiary Insurance Company:		Card provided for scanning ☐
	Insured's Name:	Birth date:	Relation to Patient:

Emergency Contact Information

Provide contact information for at least one person other than the patient or the insured.

*Name (first, MI, last):	*Relation	*Phone:
*Address:	*City, State, Zip:	
Name (first, MI, last):	Relation	Phone:
Address:	City, State, Zip:	
Name (first, MI, last):	Relation	Phone:
Address:	City, State, Zip:	

*required

Additional Information

Preferred retail pharmacy:	Preferred mail-order pharmacy:

Our office uses an automated system to remind you of upcoming appointments.

Preferred number to call for appointment reminders: ☐ Home ☐ Mobile ☐ Work

Preferred time of day to call:
☐ Morning (8:00 am to noon); ☐ Afternoon (noon to 5:00 pm); ☐ Evening (5:00 pm to 9:00 pm);
☐ Other (specify): _____

Would you also like to receive a text message reminder? ☐ Yes, carrier _____; ☐ No

Preferred language for reminders: ☐ English ☐ Spanish

Patient Portal

The patient portal is simply a secure website provided by our medical records software company that we can use to interact with patients. Through this website, patients can obtain information about statements and lab results, and can receive reminders about appointments. The portal is available as a free service to all patients, and will be enhanced over time to provide more and more options. To use the portal, you must obtain a User Name and Password, and **you must have an email address that you check consistently**.

You can access our website at anytime at www.rockymountaindiabetes.com. To gain access to the patient portal simply fill in the information below. Our staff will "web-enable" your account and assign a User Name and Password to you. Once you login, you can change your password to something you will remember more easily. On your first visit to the portal, you will need to accept the consent. Please read the consent carefully, among other things, you agree to use the portal only for **non-urgent** communications.

A very unique service of our practice is to send you a "Lab Letter" that explains results for common lab tests along with comments from the providers, and includes previous results. As part of providing your e-mail address and being set up to access the patient portal, this letter will be sent to your e-mail rather than through regular mail. The letter will be sent as an encrypted attachment to ensure privacy and security. To open the e-mail attachment, you will be required to input a special code that we will provide to you. To opt out of this service, notify our staff.

e-mail address:_____

preferred user ID:_____

Assignment, Release, and Financial Responsibility.

By signing below, I authorize release of medical information to process claims to my insurance company and request that benefits be paid directly to Rocky Mountain Diabetes and Osteoporosis Center PA. Regulations pertaining to medical assignment of benefits apply.

I understand and agree that regardless of my insurance sources, I am ultimately responsible for the balance of my account for any professional services rendered.

I acknowledge that I have received a copy of the Rocky Mountain Diabetes and Osteoporosis Center Notice of Privacy Practices and I authorize the Center to use private patient information as indicated in the notice.

Medicare beneficiaries: I request that payment of authorized Medicare benefits be made to either me or on my behalf for any services furnished me by Rocky Mountain Diabetes and Osteoporosis Center PA. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

I have read all the information on this form and certify this information to be true and correct to the best of my knowledge. This consent is valid from the date executed until revoked in writing by myself. Further, I permit a copy of this authorization to be used in place of the original.

*Signed: _____ *Date: _____

*Printed Name:_____

If not signed by the patient, please indicate relationship to the patient (e.g., parent)

Relationship: _____

*required