Rocky Mountain Diabetes Center

Patient Registration (Update)

Patient Information

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

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

Ethnicity:
- ○ Hispanic
- ○ Non-Hispanic

Preferred Language: _____

Responsible Party (if other than patient)

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

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:	

Patient Registration (Update)

Insurance Information We must have a current copy of your insurance card(s) to file your insurance for you.			
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:

*required

Signature of patient/guardian: Date:

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