Alpine Medical Group, LLC Internal Medicine Division 1060 E 100 S Ste. L-10 SLC, UT 84102
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PATIENT INFORMATION

Name: _____ Gender: M/F Birthdate: _____

SS# _____-_____-_____ Best Contact Phone _____ Alt. Phone _____

Address _____ City _____ State ____ Zip_____

Email _____ Marital Status: _____

Employer: _____ Office Phone: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

SPOUSE INFORMATION

Name: _____ Gender M/F Birthdate: _____

Phone: _____ Employer: _____ Phone _____

EMERGENCY CONTACT

Name: _____ Phone: _____ Relation _____

INSURANCE INFORMATION

Primary: _____ Secondary: _____

Policy # _____ Policy # _____

Policy Holder: _____ Policy Holder: _____

Birthdate: _____Relationship: _____ Birthdate: _____ Relationship: _____

I agree that the above information is accurate to the best of my knowledge and I agree to the policies and procedures listed on the reverse side of this form.

In accordance with the HIPAA Act, I acknowledge that Alpine Internal Medicine made a “Notice of Privacy Practices” available to me.

I give consent to receive calls and messages on my mobile device.

Signature _____ **Date** _____