MountainStar
St. Mark's Obstetrics & Gynecology Associates

Patient Information

Name: (Last) _____ **(First)** _____ **(Middle Initial)** _____

Address: _____

City, State, Zip: _____

Home Phone #: _____ **Cell #:** _____ **Work #:** _____

Date of Birth: MM _____/DD_____YYYY/_____ **SSN:** _____/_____/_____ ☐ **Female** ☐ **Male**

Email Address: _____

Marital Status: ☐ Married ☐Single ☐ Divorced ☐ Partner ☐Widowed ☐ Legally Separated

Race: ☐ American Indian/Alaska Native ☐Asian ☐ Asian Indian ☐Black/African American ☐Pacific Islander/Native Hawaiian

☐ White ☐Other ☐Unknown/Declined **Ethnicity:** ☐ Hispanic or Latino ☐Not Hispanic or Latino ☐Other ☐Unknown/Declined

Primary Language: ☐ English ☐ Spanish ☐ Other_____

Employment: ☐ Employed ☐ Not Employed ☐Self Employed ☐ Retired **Employment Status**: ☐ Full Time ☐ Part Time ☐ Student

Employer: _____

Responsible Party *(If Different than patient)*

Name: (Last) _____ **(First)** _____ **(Middle Initial)** _____

Address: _____

City, State, Zip: _____

Home Phone #: _____ **Cell #:** _____ **Work #:** _____

Date of Birth: MM _____/DD_____YYYY/_____ **SSN:** _____/_____/_____ ☐ **Female** ☐ **Male**

Email Address: _____

Emergency Contact

Name: _____ **Phone #:** _____ Relationship: _____

Primary Insurance Information

Insurance Company: _____ **Phone #** _____

Name of Insured: _____ **Patient Relationship to Insured:** _____

Subscriber ID #: _____ **Group #:** _____

Insured's Date of Birth: _____/_____/_____ **Insured's SSN:** _____/_____/_____

Secondary Insurance Information

Insurance Company: _____ **Phone #** _____

Name of Insured: _____ **Patient Relationship to Insured:** _____

Subscriber ID #: _____ **Group #:** _____

Insured's Date of Birth: _____/_____/_____ **Insured's SSN:** _____/_____/_____

Preferred Lab and Pharmacy

Lab: _____ **Pharmacy:** _____
I understand that I am responsible for providing the name of the laboratory my insurance requires I use. St. Marks OBGYN defaults to MSCL/PAML

Medigap Authorization *(Medicare Patients Only)*

I request that payment of Medigap (Medicare Supplement) benefits be made on my behalf to the provider for services rendered by that provider. I authorize the release of medical information to information to Medigap insurer to determine the benefits payable for related services.

_____ Date: _____
Patient/Guarantor Signature

Patient Prescription Policy

Patients who are given prescriptions for medications, especially for narcotics and/or pain, agree to abide by the following rules:

1. The patient will take the medication only as prescribed. Patients who take more than the prescription indicated will not be prescribed additional medications.
2. Only patients for whom the prescription is written are allowed to use the medications. There will be ***no refills*** for lost, stolen, or misplaced narcotic prescriptions.
3. Any attempt to obtain additional medications from another physician may be considered attempting to abuse narcotic prescriptions and may be referred to legal authorities for appropriate action and/or dismissal from practice.
4. There will be ***no refills*** of narcotics after business hours or weekends.
5. Patients will give a minimum of ***48 hours notice*** when requesting prescription

I understand and agree to the above statements.

_____ Date: _____
Patient/Responsible Party Signature

How Did You Hear About Us?

☐ Billboard
☐ Clinic Signage
☐ Clinic Website
☐ ED – Emergency Department
☐Facebook
☐Former Patient
☐ Free Pregnancy Test
☐Hospital Admission
☐ Insurance
☐Mail Advertisement
☐Newspaper/Magazine Ad
☐Online Review Site
☐Online Search Engine
☐Phone Book
☐Physician Referral
☐Smartphone App
☐Twitter
☐Word of Mouth
☐YouTube
☐Other

I agree that the information supplied on this form is accurate and up- to- date to the best of my knowledge

_____ **Date: _____**

Patient/Responsible Party Signature