

**Patient Registration Form  
Maternal-Fetal Services of Utah**

_____
Patient #
_____
PSR Initials

**PATIENT INFORMATION**

*Please Print*

Dr.  Mr.  Mrs.  Ms.  Jr.  Sr.  Other \_\_\_\_\_

Patient's Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_

Also Known As Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_

Physical Address \_\_\_\_\_

City, State, ZIP (+4) \_\_\_\_\_

Mailing Address \_\_\_\_\_

City, State, Zip (+) \_\_\_\_\_

Employer \_\_\_\_\_ Employer Address \_\_\_\_\_

Alternate Contact Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Patient Relationship to Alternate Contact \_\_\_\_\_

Marital Status  Married  Single  Divorced  Widowed  Legally Separated  Other

Employment Status:  Employed  Full-time  Part-time  Self-Employed  Unemployed  Full-Time Student

Part-Time Student  Retired Email \_\_\_\_\_

Phone Numbers: Home \_\_\_\_\_ Work \_\_\_\_\_ Cellular \_\_\_\_\_

Female  Male Social Security Number \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Responsible Party Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_

Also Known As Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_

Mailing Address \_\_\_\_\_

City, State, ZIP (+4) \_\_\_\_\_

Employment Status  Employed  Full-Time Student  Part-Time Student  Retired  Self-Employed  Unemployed

Employer \_\_\_\_\_ Employer Address \_\_\_\_\_

Phone Numbers Home \_\_\_\_\_ Work \_\_\_\_\_ Cellular \_\_\_\_\_

Female  Male Social Security Number \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Co-Payment Amount \_\_\_\_\_ Patient Relationship to Responsible Party \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

*(provide your insurance card to the front desk at check-in)*

Name of Insured \_\_\_\_\_ Patient Relationship to Insured \_\_\_\_\_

Insurance Company/Phone Number \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

Subscriber ID (Policy Number) \_\_\_\_\_ Group ID \_\_\_\_\_

Effective Date \_\_\_\_\_ Termination Date \_\_\_\_\_  Female  Male

Insured Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_\_ Insured Social Security Number \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Insured Employer \_\_\_\_\_ Employer Address \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

*(provide your insurance card to the front desk at check-in)*

Name of Insured \_\_\_\_\_ Patient Relationship to Insured \_\_\_\_\_

Insurance Company/Phone Number \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

Subscriber ID (Policy Number) \_\_\_\_\_ Group ID \_\_\_\_\_ Copay Amount \_\_\_\_\_

Effective Date \_\_\_\_\_ Termination Date \_\_\_\_\_  Female  Male

Insured Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_\_ Insured's Social Security Number \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Insured Employer \_\_\_\_\_ Employer Address: \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I authorize the release of any information requested by my insurance carrier(s) that is necessary to process unpaid claims and also authorize payment "assigned" insurance benefits to Appledore Medical Group.

**Patient (or Responsible Party) Signature** \_\_\_\_\_ **Date** \_\_\_\_\_