Mountain View Hospital
CENTER FOR WELLNESS & RECOVERY

PATIENT INFORMATION:

Last Name:____________________ First Name:___________________ Mid Initial:_____ DOB:____/____/_____

Address:__________________________________ City:________________ State:________ Zip:___________

Phone(Primary):(_____)__________-_____________ Phone(Secondary): (_____)__________-_____________

Email: ____ Social Security #: ____________________________

Race:________________ Ethnicity:________________ Marital:________________ Smoker:_______________

EMERGENCY CONTACT:

Last Name:___________________ First Name:___________________ Phone: (_____)________-___________

Relationship to Patient:____ DOB: ____/____/_____

Address:__________________________________ City:________________ State:________ Zip:___________

SPOUSE/GUARDIAN INFORMATION:

Last Name:____________________________ First Name:__________________________ Mid Initial:_______

Relationship to Patient:______________________ DOB: ____/____/_____ Phone: (_____)________-__________

Address:__________________________________ City:________________ State:________ Zip:___________

Home Phone:(_____)________-___________ Cell Phone:(_____)________-___________

INSURANCE INFORMATION:

PRIMARY:
Insurance Company:_______________________________ Policy Holder:______________________________

DOB: ____/____/_____ ID#:___________________ Group #:___________________ Plan Code:_____________

Employer:____ ☐ Full Time ☐ Part Time

SECONDARY:
Insurance Company:_______________________________ Policy Holder:______________________________

DOB: ____/____/_____ ID#:___________________ Group #:___________________ Plan Code:_____________

Employer:____ ☐ Full Time ☐ Part Time