HIGHLAND FAMILY PRACTICE

4460 S. HIGHLAND DR. # 400
SALT LAKE CITY UT, 84124
(801) 272-4111

DATE _____

PATIENT NAME_____ PREFERRED NAME_____
FIRST M.I. LAST

PATIENT ADDRESS _____
STREET ADDRESS (PLEASE NO P.O. BOXES)

CITY STATE ZIP CODE

HOME PHONE # _____ DATE OF BIRTH _____/_____/_____ GENDER M ○ F ○

WORK PHONE # _____ MARITAL STATUS S ○ M ○ W ○ D ○ RACE_____

CELL PHONE # _____ TEXT MESSAGING OK? Yes ○ No ○

ETHNICITY_____ EMPLOYER

WORK STREET ADDRESS _____

_____
CITY STATE ZIP CODE

PERSON RESPONSIBLE FOR PAYMENT _____
FIRST M.I. LAST

MAILING ADDRESS_____
STREET ADDRESS (NO PO BOXES)

CITY STATE ZIP CODE

HOME PHONE # _____ WORK PHONE # _____

RELATIONSHIP TO PATIENT _____ DATE OF BIRTH _____/_____/_____

INSURANCE #1 _____ GROUP # _____ I.D._____

ADDRESS_____ NAME OF INSURED _____

_____ RELATIONSHIP TO PATIENT_____ D.O.B. _____
CITY STATE ZIP CODE

EMPLOYER _____

INSURANCE # 2 _____ GROUP # _____ I.D._____

ADDRESS_____ NAME OF INSURED _____

_____ RELATIONSHIP TO PATIENT _____ D.O.B._____
CITY STATE ZIP CODE

EMPLOYER _____

EMERGENCY CONTACT # 1_____ PLEASE LIST ALL MEDICATION ALLERGIES:

PHONE # _____ _____

EMERGENCY CONTACT # 2_____ AUTHORIZATION FOR ELECTRONIC CONFIRMATIONS?

YES ○ NO ○

PHONE # _____ PHARMACY_____

DO YOU HAVE A LIVING WILL OR ADVANCED DIRECTIVE? PHARMACY PHONE # _____

_____

<OVER>