Rocky Mountain Infectious Diseases, PC

1450 East A Street, Suite 1, Casper, Wyoming 82601 ● (307) 234-8700

Patient Insurance Registration

PRIMARY INSURANCE *Provide Copy of Insurance Card to Skip Bold Questions*

Insurance Company_____**Policy#**_____**Group#**_____

Patient is the Insured? ☐ Yes (Skip below section) ☐ No (Provide copy of driver license) Relationship to patient_____

Insured Name_____SS#_____

Sex ☐ M ☐ F Birthdate_____☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Minor ☐ Other Race_____

Physical Address_____City_____State_____Zip_____

Mail Address_____City_____State_____Zip_____

Insured Employer_____Occupation_____

Address_____City_____State_____Zip_____

Cell Phone_____***Home Phone***_____***Work Phone***_____

Email_____Contact Preference ☐ Cell ☐ Home Phone ☐ Work Phone ☐ Email

SECONDARY INSURANCE *Provide Copy of Insurance Card to Skip Bold Questions*

Insurance Company_____**Policy#**_____**Group#**_____

Patient is the Insured? ☐ Yes (Skip below section) ☐ No (Provide copy of driver license) Relationship to patient_____

Insured Name_____SS#_____

Sex ☐ M ☐ F Birthdate_____☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Minor ☐ Other Race_____

Physical Address_____City_____State_____Zip_____

Mail Address_____City_____State_____Zip_____

Insured Employer_____Occupation_____

Address_____City_____State_____Zip_____

Cell Phone_____***Home Phone***_____***Work Phone***_____

Email_____Contact Preference ☐ Cell ☐ Home Phone ☐ Work Phone ☐ Email

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

Received and Reviewed by _____