

Patient Registration Update

LEGAL Last Name _____ First _____ Middle Initial _____

Mailing Address: _____

Physical Address: _____

City _____ State _____ ZIP: _____

If there is an address change, does this apply to any other family members who are patients at the Bozeman Clinic? Yes _____ No _____

List members _____

Best phone # to contact you: _____ Other phone: _____

May we leave medical information on your answering machine/voice mail? Yes _____ No _____

Employer / Occupation: _____ Work phone: _____

Emergency Contact Information - a friend or relative

1) Name _____ Phone: _____ Relationship: _____

2) Name _____ Phone: _____ Relationship: _____

Payment Agreement

- 1) The person accompanying a minor is responsible for payment.
- 2) I understand that payment is required at the time of service.
- 3) I am prepared to pay by : Cash ____ Check ____ Credit Card (MasterCard, Visa, Discover, AMX) _____
- 4) ***I understand that should I default on payment of my account and collection agency services are required, all costs of collection including attorney and court costs will be added to the balance of my account.***

Signature _____ Date _____