Bozeman Clinic
931 Highland Blvd #3360
Bozeman, MT 59718
Phone: 406-587-4242 / FAX: 406-587-3507

PATIENT REGISTRATION FORM

Have you or anyone in your family been seen in our Clinic before? Yes_____ No _____
If yes, who? ___________________________________ How are you related? ___________________

Is this visit a result of a: *Work related injury?* Yes ___ No ___ *Motor Vehicle Accident?* Yes ___ No ___

Patient Information ---- *Photo ID is required for new patients due to Federal regulations.*

LEGAL Last Name _________________________________First______________________Middle Initial______

Mailing Address______________________________City___________________State__________ZIP_________

Physical Address______________________________City___________________State_________ZIP_________

Date of Birth ___________________ SSN_________________________ Male ____ Female _____

Best phone # to contact you: ___________________________ Other phone: ____________________

May we leave medical information on your answering machine/voice mail? Yes _______ No_____

Employer / Occupation: ____________________________________ Work phone: ___________________

Spouse's Name: ______________________________________ Phone: _______________________
Spouse's Employer ____________________________________ Work phone:__________________

Guardian Information – Please complete if the Patient is under age 18

Parent /Guardian LEGAL Last Name__________________________First_______________Middle Initial______
Mailing Address: ____
City ________________________________ State ______________________ ZIP: ______________________

Date of Birth _____________________ SSN________________________ Male _____ Female _______

Best phone # to contact you: ___________________________ Other phone: ________________________

Employer /Occupation:____Workphone:____________________

Emergency Contact Information is required - a friend or relative

1) Name___________________________________ Phone: _________________ Relationship: _____________
2) Name___________________________________ Phone: _________________ Relationship: _____________

I hereby acknowledge that I have been presented with a copy of The Notice to Privacy Practices. _____(Initial)

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_____________________

In office use only: Date ____________ Card effective date ______________ Initials_______

Insurance Information

Please provide current insurance card for the receptionist to copy.

The Bozeman Clinic is contracted with the following insurance companies and will file your claim.

Medicare: ______ Blue Cross Advantage: _____ Blue Cross: ______ HMK (CHIPS)____ EBMS: ____
Pacific Source: ____ Allegiance: ______ Cigna: ______ Medicaid: ____ United HealthCare: ______

I am aware insurance companies have the right to request and review my medical information in order to process my medical claim(s).

I do not have insurance __________ I have Private Insurance not listed above___________________
(insurance name)

Patient Name: ____ DOB ____________

Insurance Subscriber Name: ______________________________

Subscriber information (this is needed if subscriber is not the patient):

Date of Birth: _________________ Phone #: ________________

Address: ____

City _____________ State__________ ZIP___________

Relationship to the Patient: _____________________

Does the Insurance information above apply to other family members who are patients in this office?

Yes ___ No ___ If yes, please list the family members:

____

____

Other Private Insurance: You will be given a copy of an itemized statement at the time of your visit. This copy can be used to file a claim. Reimbursement/explanation of benefits will be sent to you directly from the insurance company.

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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: _____________________