In Office Use: Chart _______ Computer______Ins_____

The Bozeman Clinic, PLLP

Account # ______________

Patient Registration Update

LEGAL Last Name ________________________First______________________Middle Initial______

Date of Birth_________________

Mailing Address____________________________City__________________State__________ZIP_________

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____________________