Glacier Family Medicine Clinic

Patient Registration

Patient's Name: _____
First MI Last

Mailing Address_____ City _____ State _____ Zip_____

Primary Contact number:(____)_____ Secondary Contact number:(____)_____

Birth date: _____ Sex: Male○Female○ SSN:_____

Marital status: Married ○ Single ○ Divorced ○ Widow/widower ○ Other

Any known allergies :_____

Employer:_____ Occupation:_____

If patient is a minor:

Name of Parent/guardian:_____Relationship:_____

Address:_____Phone number:(____)_____

Insurance coverage

Primary Insurance: _____ Secondary Insurance: _____

Subscriber name: _____ Subscriber name:_____

Subscriber employer: _____ Subscriber employer: _____

Subscriber Birth date : _____ Subscriber Birth date: _____

Emergency Contact

Name/Relationship:_____Phone number:_____

_____ (initial) I understand that I am ultimately responsible for all charges. I authorize my insurance company(s) to pay GFMC for those charges I have not paid in full and which are filed by the Clinic on my behalf. In the event that my insurance company(s) pay GFMC a fee that has already been paid. I understand that I will be promptly reimbursed.

_____ (initial) I consent to treatment by the providers at GFMC and authorize GFMC to release any medical Information required by my insurance company or worker's compensation carrier for the processing of any medical claims filed on my behalf.

_____ (initial) I acknowledge that I have reviewed GFMC's *Notice of Privacy Practices*, which describes how medical information about me may be used and disclosed.

_____ (initial) I affirm that the above information is true and correct to the best of my knowledge.

_____ _____

Patient/Guardian Signature Date

Revised 01-05-2011