

Patient Registration

Welcome to Bozeman Creek Family Health. We are committed to providing the best, most comprehensive care possible. Please assist us by providing the following information. All information is confidential and only released with your consent.

Thank you for allowing us this opportunity to care for you!

Patient Information

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Sex: M / F Social Security #: _____

Preferred Language: _____ Ethnicity (please circle): Hispanic Non-Hispanic

Race (please circle): White Black Asian Indian/Alask Pac Isle Other/Mult

Parent(s) / Guardian(s) Name (Minors Only): _____

Mailing/Billing Address: _____

City: _____ State: _____ Zip Code: _____

Primary #: _____ Secondary #: _____

Employer: _____ Work #: _____

Email: _____ Would you like to receive your billing statements via email? Yes ___ No ___

May we leave clinical messages on your answering machine or voicemail? [] yes [] no #: _____

How were you referred to our practice? (please ck) [] Doctors Office _____ [] Current Patient/ Friend _____

[] Insurance [] Phone Book [] Website [] Event _____ [] Internet Search _____ [] Other _____

In Case of An Emergency Please Contact

Name: _____ Relationship: _____ Phone #: _____

Financial Information

Insurance Company: _____ Policy #: _____ Group#: _____

If you are NOT the policy holder on your insurance account, please fill out the following:

Subscriber: _____ **Subscriber DOB:** _____