**Glacier Community Health Center / Glacier Dental Clinic**

**PATIENT INFORMATION**

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| **Patient Information**   |

Name: Birthdate: Age: Sex: M F

Mailing Address: City State Zip

Home Phone: Work Phone: Cell Phone:

OK to leave message at: Home? Y\_\_ N\_\_ Work? Y\_\_ N\_\_ Cell? Y\_\_ N\_\_

Email: Employer:

Marital Status: M S W D Sep Social Security #:

Race: Asian African American Native American White More than 1 race

Ethnicity*:* Hispanic Non-Hispanic Language Preferred: English\_\_ \_ Other

Are you a veteran of the armed forces? Yes No Pharmacy Name:

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| **Spouse or Parent Information** |

Name: Birthdate: Age: Sex: M F

Social Security #: Work Phone:

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| **Insurance Information** *(We will need to make a copy of your insurance cards.)* |

***Primary Medical Insurance Company***

***Secondary Medical Insurance Company***

***Dental Insurance Company***

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| **Billing Information**  |

***Person Responsible for bill*** Relationship

Billing Address: City State Zip

Phone # Work Phone

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| **EMERGENCY INFORMATION** |

Name of relative or friend not living with you that we can contact in case of an emergency:

Name: Relationship Phone

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| **TREATMENT, ASSIGNMENT & RELEASE:** I hereby request and authorize Glacier CHC and its providers to treat me for health problems or conditions identified in the course of assessment and evaluation. I also hereby authorize direct payment of benefits to be paid directly to the provider. I understand and agree to pay any and all charges that exceed or that are not covered by insurance. I authorize the provider or insurance company to release any medical, dental or incidental information that may be necessary for either medical or dental care or in processing applications for payment benefits for services rendered.Signed: Date:  |