Ravalli Family Medicine Patient Registration/Financial Agreement (Child) Thank you for taking the time to complete this form. This information is necessary for the preparation of your clinical records. You are responsible for all charges billed. Our credit office personal will be happy to discuss a payment schedule that is most convenient for you.

	ASE PRINT AND COMPLETE ENTIRE FOR TO BILL INSURANCE WITHOUT BIRTHD				
Patient information:		<u>111 Lo 1110 00#.</u>			
Patient Name:	Middle	Last			
	City:				
Home address:	City:	Zip			
Home phone #:	$_$ \Box Male \Box Female Birthdate:	SS#:			
Ethnicity: 🗆 Hispanic or Latin	no \Box Not Hispanic or Latino \Box	Decline			
Email address:					
Race: 🗆 American Indian or	r Alaska Native □ Asian □ Black/A	African American			
	other Pacific Islander \Box White				
What is your preferred spoken la	inguage?				
MOTHER'S NAME:					
Address: \Box same as above	City:	Zip:			
	Cell phone #:				
f you cannot reach me at home it is	OK to try me at: \Box Work \Box Cell \Box It is n	not OK to call other numbers			
FATHER'S NAME:					
Address: \Box same as above	City:	Zip:			
	Cell phone #:				
f you cannot reach me at home it is	OK to try me at: \Box Work \Box Cell \Box It is n	ot OK to call other numbers			
Emergency Contact (other tl	han parents):				
Name:	Relationship:				
Address:	Phone:				
Person responsible for accou	unt:				
Name:	Address:				
	Birthdate:SS				
	Phone #:				
	e cannot bill insurance without this				
		-			
	SS#:				
authorize the release of any medi	ical information which may be requested t	to process claims for paym			

of medical services through my insurance carrier, prepaid medical plan, or government agency. I authorize payments to be made to the clinic or providers.

□ Credit/Debit card If no insurance: \square Cash

Ravalli Family Medicine 411 W Main Street Hamilton, MT 59840

I assume liability for all non-covered charges and deductibles. By signing this form I acknowledge that I have received a copy of the Notice of Privacy Practices and payment policy of Ravalli Family Medicine.

PATIENT CONSENT TO BE TREATED

I consent to being treated as a patient at Ravalli Family Medicine, by the providers and their nursing staff to include the examinations, treatments, diagnostic tests, injections and medications which they believe are advisable and necessary for my care. If I need to be referred to a subspecialty physician, I hereby authorize Ravalli Family Medicine to make my medical information available to the appropriate consultant.

Patient Notification:

I agree that medical information may be left on my answering machine (circle one): Yes No

I agree that medical information may be given to:

Name: _______Relationship: ______

Phone:			
-			

Signature of Responsible Person

Date

Relationship

Patient Name:		Date:				
Age: Birthdate: Date of last physical exam:						
Physicians you are curr	Physicians you are currently seeing:					
Referred by:						
	Check conditions you c	urrently have or have had				
_ AIDS	_ Depression	_ Incontinence	Women only:			
_ Alcoholism	_ Emphysema	_ Kidney Disease	_ Abnormal periods			
_ Anemia	_ Epilepsy (seizures)	_ Liver Disease	_ Hot flashes			
_ Angina	_ Glaucoma	_ Migraine Headaches	Date of last menstrual			
_ Anorexia	_ Gout	_ Multiple Sclerosis	period:			
_ Anxiety	_ Hay Fever	_ Osteoporosis				
_ Arthritis	_ Hearing loss	_ Pacemaker	Date of last pap smear:			
_ Asthma	_ Heartburn/Acid Reflux	_ Polio	Abnormal: Y or N			
_ Bleeding disorders	_ Heart Disease	_ Prostate Problem				
_ Breast lump	_ Heart Attack	_ Psychiatric Care	Have you had a			
_ Bronchitis	_ Heart murmur	_ Rheumatic Fever	mammogram: Y or N			
_ Bulimia	_ Hepatitis	_ Scarlet Fever	Date:			
_ Cancer:	_ Hernia	_ Stroke				
_ Cataracts	_ Herpes	_ Suicide attempt	Are you pregnant: Y or N			
_ COPD	_ Hiatel Hernia	_ Thyroid Problems	Number of pregnancies:			
_ Chemical Dependency	_ High Blood Pressure	_ Tuberculosis	Number of miscarriages:			
_ Diabetes	_ High Cholesterol	_ Ulcers	Number of children:			
	_ HIV positive	Other:				

Ravalli Family Medicine Confidential Health History

List Medications you are currently taking				
Medication	Dose and frequency			
List Medication allergies (if none please check box below):				

Social History: circle or explain as				
necessary				
Marital Status				
Place of employment				
Exercise	Туре:			
	Frequency:			
Smoking	(circle) Previous Current			
	Amount per day:			
	🗆 none			
Chewing	(circle) Previous Current			
tobacco	Amount per day:			
Alcohol	Amount per week:			
Special diet	(circle) Vegetarian Vegan			
	Low-carb Other:			
	□ none			

YearSurgery/Hospitalization/FracturesReasonPrevious Tests: Cardiac Catheterization: Date: Colonoscopy: Date: EGD: D	Past Medical History						
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Thyroid Problems	Daughters			_			
				-	<u> </u>	-	
						Other:	

To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.