Ravalli Family Medicine
Patient Registration/Financial Agreement (Adult)

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.

PLEASE PRINT AND COMPLETE ENTIRE FORM.
WE ARE UNABLE TO BILL INSURANCE WITHOUT BIRTHDATES AND SS#.

Patient information:

Patient Name: ____
First Middle Last

Mailing address: ______________________________ City: _________________ Zip_________

Home address: _______________________________ City: _________________ Zip _________

Phone numbers: Home:______________ Work:______________ Cell:_______________

If you cannot reach me at home it is OK to try me at: ☐ Work ☐ Cell ☐ It is not OK to call other numbers

Email address: _______________________ ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Birthdate: _____________ SS#: ____________________________ ☐ Male ☐ Female

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

What is your preferred spoken language? ____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other ☐ Decline

Employer: _____________________________ Address: ________________________________

Occupation: ____________________________

Spouse Name: __________________________ Birthdate: ____________ Contact #:__________

Emergency Contact (other than spouse):

Name: ___________________________________ Relationship: __________________________

Address: ____ Phone: _______________________

Insurance: (We cannot bill insurance without this information)

☐ check if you are primary on insurance

Primary insured's name: ____

Birthdate: __________________ SS#: _______________________

Ravalli Family Medicine
411 W Main Street
Hamilton, MT 59840

I authorize the release of any medical information which may be requested to process claims for payment of medical services through my insurance carrier, prepaid medical plan, or government agency. I authorize payments to be made to the clinic or providers.

If no insurance: ☐ Cash ☐ Credit/Debit card

I assume liability for all non-covered charges and deductibles.

Privacy Policy:
By signing this form I acknowledge that I have received a copy of the Notice of Privacy of Privacy Practices from 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

Ravalli Family Medicine Confidential Health History

Patient Name: ____ Date: ____________

Age: ______ Birthdate: _______________ Date of last physical exam:__________________

Physicians you are currently seeing: ____

Referred by:____

Check conditions you currently 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: ________________	

List Medications you are currently taking	
Medication	Dose and frequency

List Medication allergies (if none please check box below):

☐ **None Known**

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

Past Medical History

Year	Surgery/Hospitalization/Fractures	Reason

Previous Tests:

Cardiac Catheterization: Date: ____________

Colonoscopy: Date: ______________

EGD: Date: ____________

EKG: Date: ____________

Bone density test: Date: ____________

Stress test: Date: _____________

Other: ________________________

Immunizations: (indicate date) ☐ Tetanus: ___________ ☐ Pneumonia: __________ ☐ Influenza: _________

☐ **None**

Family History: fill in the following about your family's medical history

Relation	current age	If deceased, cause & age
Father		
Mother		
Brothers		
Sisters		
Sons		
Daughters		

Family Medical Conditions: Check any that apply to your family

✓	Disease	Relationship to you
	Alcoholism/Drug Abuse	
	Arthritis	
	Asthma	
	Blood Disease	
	Cancer, type:___________	
	Convulsions/Seizures	
	COPD/emphysema	
	Diabetes	
	Heart Disease	
	High Cholesterol	
	High Blood Pressure	
	Stroke	
	Kidney Disease	
	Mental Disorders	
	Migraine Headaches	
	Thyroid Problems	
	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.

_________________________________ ____ _____________

Signature of Patient, Parent, Guardian | Please print name of patient | Date