Thank you for choosing our clinic!

Patient Information

Last Name: ______________________ **First Name:** ______________________ **MI:** ________

Birthdate: ______________ Sex: ❍ M ❍ F SSN: ______________

E-Mail: ______________________ ❍ Please do **NOT** send electronic billing statements.

Mailing Address: ______________ City: ________ State: ______ Zip: ______

Cell: ______________ Home: ______________ ❍ Check here if it is okay to leave a message on either number.

Marital Status: ❍ Married ❍ Single ❍ Divorced ❍ Legally Separated ❍ Widowed ❍ Life/Domestic Partner

Preferred Language Spoken: ❍ English ❍ Spanish ❍ Other: ______________

Race: ❍ White ❍ Native American ❍ Pacific Islander ❍ African American ❍ Asian ❍ Other: ______________

Ethnicity: ❍ Hispanic or Latino ❍ NOT Hispanic or Latino

Employment: ❍ **Full time** ❍ **Part time** ❍ **Self Employed** ❍ **Retired** ❍ **Student** ❍ **Disabled** ❍ **Unemployed**

Name of Employer/Company: ______________________ **Work Phone:** ______________

In case of an emergency, please contact: ______________________ **Phone:** ______________

Relationship: ______________

Responsible Party

❍ **Same as above**

(complete the section below if patient is 18 years or younger)

Last Name: ______________________ **First Name:** ______________________ **MI:** _____

Birthdate: ______________ Sex: ❍ M ❍ F Relationship to Patient: ______________

Mailing Address: ______________ City: ________ State: ______ Zip: ______

Home Phone: ______________ Cell Phone: ______________

Employment: ❍ **Retired** ❍ **Self Employed** ❍ **Other:** ______________ ❍ **Full time** ❍ **Part time**

Name of Employer/Company: ______________________ **Work Phone:** ______________

Authorization to Release Information to Another Entity

(not needed for patients under 18)

I allow Sublette County Hospital District to release ❍ **Medical** ❍ **Financia**l (please mark) information when I am unavailable to personally authorize a discussion regarding my chart/account. I only allow this release to the following named person(s):

Named Person(s): ______________________ **Relationship:** ______________

Consent for Treatment / Health Authorization Record

I voluntarily agree to receive healthcare services at Sublette County Hospital District (SCHD) for evaluation, treatment, or testing by SCHD employees. I understand and agree that I will participate in my treatment plan, and that I may discontinue treatment or withdraw my consent for treatment at any time. I understand that this treatment may incur a financial responsibility. Consent is valid for 365 days.

Signature: ______________________________________ ❍ **Parent / Legal Guardian**

Printed Name: ______________________ **Date:** ______________

Insurance Information

❍ **No Insurance** ❍ **Insurance Card(s) Provided**

My PRIMARY Insurance is: ❍ **Medicare** ❍ **Medicaid** ❍ **Other: -----------------Please continue to the next section.**

Insurance Name: ______________________ **Member ID:** ______________________

Claims Mailing Address: ______________________________ **Phone:** ______________

Policy Holder Name: ______________ **DOB:** ______________ **Sex:** ❍ **M** ❍ **F**

Policy Holder's Relationship to Patient: ______________

My SECOND Insurance is: ❍ **Medicare** ❍ **Medicaid** ❍ **Other:** ______________________

Member ID: ______________________

Claims Mailing Address: ______________________________ **Phone:** ______________