## Glacier Community Health Center / Glacier Dental Clinic

# PATIENT INFORMATION

**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:_____

**Spouse or Parent Information**

Name:_____ Birthdate:_____ Age:_____ Sex: M F

Social Security #: _____ Work Phone:_____

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

***Primary Medical Insurance Company***_____

***Secondary Medical Insurance Company***_____

***Dental Insurance Company***_____

**Billing Information**

***Person Responsible for bill***_____ Relationship_____

Billing Address:_____ City_____ State_____ Zip_____

Phone #_____ Work Phone_____

**EMERGENCY INFORMATION**

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

Name:_____ Relationship_____ Phone _____

**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:_____