

# Patient Registration



This section must be completed for all patients:

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_  
*Last* *First* *M.I.*

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Social Security # \_\_\_\_\_ Sex Male  
Female

## Address

Mailing Address \_\_\_\_\_  
*City* *State* *Zip*

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Marital Status: Single Married Divorced Widowed Separated

Patient's Occupation: \_\_\_\_\_ Phone: \_\_\_\_\_ Ext. \_\_\_\_\_

## Primary Subscriber to Insurance Information – REQUIRED FOR ALL PATIENTS

Name \_\_\_\_\_  
*Last* *First* *M.I.*

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Social Security # \_\_\_\_\_ Sex Male  
Female

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

## Insurance & Payment

Primary Policy Name & ID Number: \_\_\_\_\_

Secondary Policy Name & ID Number: \_\_\_\_\_

### ***For Montana Medicaid Patients Only (please initial):***

\_\_\_\_\_ I ACKNOWLEDGE THIS OFFICE IS NOT A PARTICIPANT IN THE MONTANA MEDICAID PROGRAM, AND I WILL BE RESPONSIBLE FOR PAYMENT FOR SERVICES RENDERED.

We are happy to file insurance claims for those health care plans with which we participate. Please note that it is the patient's responsibility to verify that our physician participates in their plan. We will also file claims for those plans in which we do not participate, which may involve an out of network deductible plus a higher percentage copay by you. However, we will not accept responsibility for collecting your insurance claim. Even though you have insurance, you are primarily responsible for payment of your account. For cosmetic procedures payment must be made at the time of service. We accept cash, check and all major credit cards.

Please be aware that you may have additional charges for biopsies taken at this visit, and your biopsy may be sent to an out of state dermatopathologist. Please advise us if your insurance will not cover providers outside of Montana and Wyoming.

If you have any insurance or payment concerns, please ask to speak to the office manager. If medical fees are a true hardship for you, please discuss this with us.

\_\_\_\_\_  
Signature of Patient (or guardian)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date