BinghamHealthcare

PATIENT INTAKE INFORMATION

Today's Date ____________________

Last Name		Gender	Religion
First Name		Marital Status	Preferred Language
Middle Initial/Name	Calling Name	Race (Circle One): *African American* *American Indian* *Asian* *Caucasian Hispanic* *Other* *Declined*	
Birth Date	SSN	Email	
Street Address		City/State	Zip
Mailing Address (If different)			
Cell Phone		Home Phone	
Allow Text Reminders Yes / No	Employment Status (Circle One): *Disabled* *Employed Full Time* *Employed Part Time* *Not Employed* *On Active Military Duty* *Retired* *Self-Employed*		
How did you hear about us?			
Occupation	Employer		
Employer Address		Employer Phone	
Primary Family Physician		Physician's Phone	

Emergency Contact

Relation Type: (Circle One) Parent Child Spouse Other ____________________			
Last Name		First Name	
Gender	Date of Birth	Phone Number	
Street Address		City/State	Zip

Guarantor (If under 18) **Note: The responsible party or guarantor is the person, of legal age, who is responsible for payment of services.**

Last Name		First Name	Relation to Patient
Gender	Date of Birth	Phone Number	
Address		City/State	Zip

NAME: ____________________ DOB: ________

Please Present Receptionist with your Insurance Cards

Primary Insurance

Primary Insurance Company			Insurance Phone Number
Insurance Address	City/State		Zip
Policy Number	Group Number		
Policy Holder Name	Policy Holder Date of Birth		Policy Holder SSN
Policy Holder Address:	City/State	Zip	Policy Holder Phone

Secondary Insurance

Secondary Insurance Company			Insurance Phone Number
Insurance Address	City/State		Zip
Policy Number	Group Number		
Policy Holder Name	Policy Holder Date of Birth		Policy Holder SSN
Policy Holder Address	City/State	Zip	Policy Holder Phone

Consent for Treatment, Financial Agreement, and Records Release

I, the undersigned, as the patient (or authorized person), consent to any treatment and/or procedures rendered to me that may, under the judgment and instruction of the treating provider, be considered advisable or necessary. I understand that if any extensive procedure or surgery is to be performed, it will be fully explained to me, including the risks and alternatives, and my specific consent will be necessary.

I understand that any ancillary services (x-rays, lab tests, etc.) that may be ordered by the medical provider while I am in the clinic **are not included in my clinic bill** and that I will be billed separately for these services.

In addition, I authorized Idaho Physicians Clinic, Bingham Memorial Hospital, along with any contracted provider services, to furnish all medical and financial information for this visit to Medicare, Medicaid, my insurance carrier and/or any agency working on their behalf. I hereby authorize payment of benefits on my behalf to any of the providers performing services related to this encounter. I understand that certain services may not be covered or may be denied by my insurance carrier and I hereby guarantee payment of the charges incurred and agree to pay any unpaid balance. I authorize the use of my medical records for performance improvement activities at this facility.

I understand that I may be charged an amount of $35 if I had an established appointment and have failed to cancel or postpone the event 24 hours in advance.

I, the undersigned, have read the above authorizations and understand the same and certify that no guarantee or assurances have been made as to the results or outcome of treatment or diagnosis.

_________ **(Initials)** I have been offered a copy of "Your Rights and Responsibilities as a Patient," and "Notice of Privacy Practices."

______________________________ ______________________________

Signature of patient or Legal Guardian ***Date/Time***

______________________________ ______________________________

Relationship to patient (if Patient is unable to sign) ***Reason patient is unable to sign***