

INTERMOUNTAIN MEDICAL CLINIC

1951 Bench Rd., Suite B * Pocatello, ID 83202 * (208)238-1000

PATIENT INFORMATION

Name(Last,First, Initial) _____ Date _____
Address _____ City, State, Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Social Security Number _____ Sex _____ Date of Birth _____
Referred By _____

Marital Status:
 1-Married 2-Single 4-Other 5-Widow 6-Separated 7-Divorced
Spouse/ Parent's name _____ Date of Birth _____

Emergency Contact _____ Relationship _____ Phone # _____
(not living with you)

PRIMARY RESPONSIBLE PARTY

(Statements will be sent to this person)

Name(Last,First, Initial) _____ Date _____
Address _____ City, State, Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Social Security Number _____ Sex _____ Date of Birth _____

Employment Status:
 1-Full Time 2-Part Time 3-Retired 4-Unemployed 5-FT Student 6-PT Student
Employed by: _____ Phone Number _____

INSURANCE INFORMATION

We are contracted with: BlueCross, BlueShield, DMBA, IHC, Medicaid, Medicare, SIPHO/MRI , Beech Street, IPN, and UPREHS

Primary Insurance _____ Effective Date _____
Address _____
City, State, Zip _____ Phone# _____
Policy Holder's Name _____ Date of Birth _____ Sex _____
Group Number _____ Policy Number _____
Employer _____

Secondary Insurance _____ Effective Date _____
Address _____
City, State, Zip _____ Phone# _____
Policy Holder's Name _____ Date of Birth _____ Sex _____
Group Number _____ Policy Number _____
Employer _____

ASSIGNMENT AND RELEASE:

_____ NON MEDICARE: I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any non-covered services. I authorize the physician to release any information required to process this claim

_____ MEDICARE: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Family Practice Group, P.A. for any services furnished me by that practice. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, formally the Health Care Financing Administration and it's agents any information needed to determine these benefits or the benefits payable for related services.

Signature _____ Date _____