

GLACIER MEDICAL ASSOCIATES

1111 BAKER AVE. ♦ WHITEFISH, MT 59937 ♦ PHONE: (406) 862-2515 ♦ FAX: (406) 862-0726

♦ ♦ PAYMENT REQUIRED THE DAY OF SERVICE ♦ ♦

PAYMENT TODAY WITH : CASH CHECK CREDIT CARD - VISA / MASTERCARD / DISCOVER APPROVED BY: _____

♦ ♦ INSURANCE CLAIM SUBMITTED ONLY IF THIS FORM IS FILLED OUT COMPLETELY ♦ ♦

PLEASE PRINT

PATIENT INFORMATION

Name (Last, First, Middle)		Sex M F	Birth Date	Soc. Sec. #
Address		Temporary Address (IF ANY)		
City, State, Zip		Temporary City, State, Zip (IF ANY)		
Home Phone ()	Cell Phone ()	Marital Status		
Employer		Work Phone ()		

RESPONSIBLE PARTY

Name (Last, First, Middle)		Sex M F	Birth Date	Soc. Sec. #
Address		City, State, Zip		
Home Phone ()	Cell Phone ()	Marital Status		
Employer		Work Phone ()		

SPOUSES INFORMATION

Name (Last, First, Middle)		Birth Date	Soc. Sec. #
Employer		Work Phone ()	

♦ ♦ INSURANCE I.D. CARD *MUST* BE PRESENTED AT *EACH* VISIT ♦ ♦

INSURANCE INFORMATION

** PRIMARY INSURANCE **	Group #	I.D. #	Phone ()
Claim Address -- Street / Box Number		Claim Address -- City, State, Zip	
Subscriber Name (Last, First, Middle)		Birth Date	Soc. Sec. #
Subscriber Address		Subscriber City, State, Zip	
Relation To Patient		Subscriber Employer	

** SECOND INSURANCE **	Group #	I.D. #	Phone ()
Claim Address -- Street / Box Number		Claim Address -- City, State, Zip	
Subscriber (Last, First, Middle)		Birth Date	Soc. Sec. #
Subscriber Address		Subscriber City, State, Zip	
Relation To Patient		Subscriber Employer	

***** THIRD INSURANCE*** (PLEASE USE BACK OF FORM)**

Emergency Contact	PHONE ()	Relation To Patient
Referred By	Relationship	

I hereby authorize payment directly to Glacier Medical Associates, otherwise payable to me. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account. I understand that I am responsible for any costs incurred should collections be required on my account. I agree to allow disclosure of all or any part of my record for insurance purposes.

PATIENT/RESPONSIBLE PARTY

_____/_____/20_____
DATE