ROCKY MOUNTAIN COLLEGE

Patient's Legal Name _____Birth Date_____

Address_____Zip Code_____ Home Phone _____
(Leave message? **Y / N**)

Sex ____ Marital Status_____ Your Local/Cell #_____
(Leave message? **Y / N**)

Patient's Emergency Contact _____ Birth date _____ Phone _____

Emergency Contact Relation to Patient _____Patient's Pharmacy/Location _____

Patient's Primary Care Physician _____Patient's Referring Doctor_____

E-Mail Address _____Preferred Language: _____

Race: **Ethnicity:**

___American Indian or Alaska Native ___Black or African American ___Other ___Hispanic or Latino

___Asian ___Native Hawaiian or Pacific Islander ___White ___Other

PARENT/ GUARDIAN INFO:
Please list all parent names, work phone for each, home address & phone number :

NAME:_____ADDRESS_____PHONE #_____

NAME:_____ADDRESS_____PHONE #_____

BILLS SHOULD BE SENT TO: _____
Relationship_____Address_____ Phone _____

DO YOU HAVE INSURANCE? Yes ____ No ____ If Yes, Name of Carrier: _____
Insurance Card Holder Name _____ Social # of card holder: _____
Home Phone Number _____ Birth date_____ Relation to Patient _____
Home Address _____

DO YOU HAVE SECONDARY INSURANCE? Yes____ No____
If Yes, Name of Carrier_____

AUTHORIZATION:
I hereby consent to treatment for myself
I authorize the release of my health information to : _____ATC, Coach, Athletic Dept _____Myself _____Parents
_____ ORTHO MONTANA, PSC _____Other_____
and to my insurance company regarding my condition and treatment as necessary to process my claims. I acknowledge I am financially responsible for any non-covered services, co-pays, and deductibles. I authorize and direct all payers to pay benefits directly to the providers for services rendered to myself.
This shall serve as a two-year authorization unless specifically revoked in writing by the undersigned.

SIGNED _____ DATE _____

COPY OF INSURANCE CARD/S