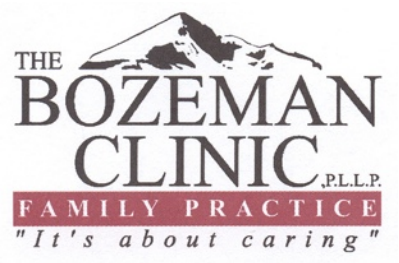
The Bozeman Clinic
931 Highland Blvd, Suite #3360
Bozeman, MT 59715
406-587-4242



Gabor Benda, MD
David McLaughlin, MD
Leonard Ramsey, MD
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Steve Roberts, DO
Heather Wheeler, MD
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PATIENT REGISTRATION Account #_____

Have you or has anyone in your family been seen in our clinic before? Yes___ No___
If yes, Who?_____ How are you related?_____

Patient's Last Name_____ Name of Spouse_____
First Name_____ Spouse's DOB_____
Address_____ Spouse's SSN_____
City_____State_____ Spouse's Employer_____
Zip_____ Phone#_____ Work Phone #_____
M___F___ Status S__M__Div__Wid__
Date of Birth_____ **Please fill out if the patient is a minor**
SSN_____ Parent's Name_____
Employer_____ Parent's Employer_____
Work Phone#_____ Work Phone#_____
Cell Phone#_____ SSN_____DOB_____
Name, Address, and phone# of a friend or relative not living with you:
_____, _____,_____

Insurance Information

Worker's Compensation Yes___ No___ (If yes, please inform the receptionist)
Medicare___ Blue Cross___ Pacific Source___ Allegiance___ Must___ Medicaid___
United Healthcare___ Cigna___ HMK___ HMK Plus___
If you selected one or more, please present your insurance(s) to the receptionist.
Insurance #1 Policy or ID#_____
Insurance #2 Policy or ID#_____
Name of Private Insurance_____
You will be given a copy of today's charges to submit to your insurance.

I hereby acknowledge that I have been presented with a copy of **The Bozeman Clinic's Notice to Privacy Practices.** (Photo ID required for new patients due to federal regulations)

Payment Agreement
1. The person accompanying a minor is responsible for payment.
2. I understand that payment is required **at the time of service.**
3. I am prepared to pay by CASH__ Check__ Credit (Master Card, Visa, Discover)__

Signature_____ Date_____