INTERMOUNTAIN MEDICAL CLINIC

1951 Bench Rd., Suite B * Pocatello, ID 83201 * (208)238-1000

PATIENT INFORMATION

Name(Last, First, Initial)_____ Date_____

Address_____ Email_____

City, State, Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

*We provide appointment reminder calls using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.

Social Security Number_____ Sex_____ Date of Birth_____

Race:

[ ] American Indian/Alaskan Native [ ] Black/African American [ ] Asian
[ ] Native Hawaiian/Other Pacific Islander [ ] White (not Hispanic or Latino) [ ] More than one race
[ ] I would rather not report

Ethnicity:

[ ] Hispanic or Latino [ ] Non Hispanic or Latino [ ] I would rather not report

Primary Language Spoken:_____

Marital Status:

[ ] Married [ ] Single [ ] Widow [ ] Separated [ ] Divorced [ ] Other

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:

[ ] Full Time [ ] Part Time [ ] Retired [ ] Unemployed [ ] FT Student [ ] 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_____

Policy Holder's Name_____ Date of Birth_____ Sex_____

Employer_____

Secondary Insurance_____ Effective Date_____

Policy Holder's Name_____ Date of Birth_____ Sex_____

Employer_____

Signature_____ ***Date***_____