2831 Fort Missoula Rd.
Physicians Building #2, Suite 104
Missoula, MT 59804

406-926-1300 | YourMigraineCare.com

PATIENT INFORMATION

Date: ______________________________

Patient Name: First __________________________ Middle Initial ______ Last ______________________________________

Address: ____ City: __________________ State: ______ Zip Code: ____________

Date of Birth: __________________ Age: _____ Sex: ___ Marital Status: ____ Social Security #________________________

Phone#: ____________________________ Cell#:______________________________ Work#: ____________________________

Email Address: ____

Employer: ____ Employer's Address: ______________________________________

Emergency Contact: ____ Relationship to Patient: __________________

Phone#: ____________________________ Cell#: ______________________________ Work#: ____________________________

Referring Provider's Name: ____ Phone#: __________________________________

RESPONSIBLE PARTY INFORMATION

Patient Name: First __________________________ Middle Initial ______ Last ______________________________________

Address: ____ City: __________________ State: ______ Zip Code: ____________

Date of Birth: __________________ Age: _____ Sex: ___ Marital Status: ____ Social Security #________________________

Relationship to Patient: ______________ Home Phone#: ______________________ Work Phone: _______________________

Employer: ____ Employers Address: _______________________________________

INSURANCE INFORMATION

Are you covered by health insurance? ______ If no, please make arrangements with our business office.

Primary Insurance: ________________________________ Policy#: ____________________ Group#: ____________________

Policy Holder Name: _____________________________________ Policy Holder Date of Birth: _________________________

Social Security Number: __________________________________ Copay: ____

Secondary Insurance: __________________________________ Policy#: ________________ Group#: ___________________

Policy Holder Name: _____________________________________ Policy Holder Date of Birth: _________________________

Social Security Number: __________________________________ Copay: ____

CONSENT FOR PAYMENT

I hereby authorize payment of medical benefits billed to my insurance to *Your Migraine Care Missoula LLC*. I have listed all health insurance plans from which I may receive benefits. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I agree to pay all copayments, coinsurance, and deductibles at the time services are rendered. I also accept responsibility for fees that exceed the payment made by my insurance, if *Your Migraine Care Missoula LLC* does not participate with my insurance. I hereby authorize *Your Migraine Care Missoula LLC* to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and healthcare operations. There will be a $30.00 charge for all returned checks. I understand that while this consent is voluntary, if I refuse to sign this consent, *Your Migraine Care Missoula LLC* can refuse to treat me. I understand this authorization can only be revoked in writing. If I revoke my consent, such revocation will not affect any actions *Your Migraine Care Missoula LLC* took before receiving my revocation.

Signature of Patient or Patient's Representative: ____ Date: _______________