Blue Mountain Clinic
Phone: 406-721-1646
Fax: 406-543-9890
610 N California St. Missoula, MT 59801

Patient Registration Form
ALL INFORMATION IS CONFIDENTIAL

Demographic Information		
Patient's legal name: Last First Middle		Preferred Name:
Sex: ☐ M ☐ F	Gender if different:	Pronouns:

*While we recognize a number of genders and sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex listed on your insurance must be used on documents pertaining to insurance, billing, and legal correspondence. If you name and pronouns are different from these, please let us know so we may address you appropriately and respectfully.

Date of Birth:	Social security# :	
Mailing address:		
City	State	Zip
Cell Phone	Home/Other Phone:	
Patient Email:	Other Parent/Guardian email:	
Language preferred:	Race:	Ethnicity:
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow ☐ Partner		
Emergency Contact Name:	Relationship to patient:	Cell Phone:
Emergency Contact Name:	Relationship to patient:	Cell Phone:

GUARANTOR (for dependents)	
Guarantor Name (Person statements should be sent to)	
Primary Insurance Plan Name:	**Policy Number:** **Group Number:**
Policy Holder Name and DOB:	**Patients' relationship to policy holder:**
Secondary Insurance Plan Name:	**Policy Number:** **Group Number:**
Policy Holder Name and DOB:	**Patients' relationship to policy holder**

AUTHORIZATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION: ALL PROFESSIONAL FORMS RENDERED ARE CHARGED TO THE PATIENT; NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDSLESS OF INSURANCE COVERAGE. ALL SERVICES PROVIDED TO YOU AS A PATIENT OF BLUE MOUNTAIN CLINIC ARE PAYABLE AT THE TIME OF SERVICE AND ARE THE SOLE RESPONSIBILITY OF YOU "THE PATIENT" AND/OR GUARANTOR OF "YOUR CHILDREN".

I HEREBY AUTHORIZE BLUE MOUNTAIN CLINIC TO FURNISH INSURANCE COMPANIES OR THE REPRESENTATIVES INFORMATION CONCERNING MYSELF AND OR MY DEPENDANT'S ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO BLUE MOUNTAIN CLINIC ALL PAYMENTS FOR MEDICAL SERVICES RENDERED BY MYSELF OR MY DEPENDENTS.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

I HEREBY AUTHORZIE AND RELEASE THE CLINICIANS AND WHOMEVER HE/SHE MAY DESIGNATE AS HIS/HER ASSISTANT TO ADMINISTER TREATMENTS, PHYSICAL EXAM, XRAY, LABORATORY PROCEDURES, MEDICAL CARE OR ANY CLINICAL SERVICE THAT HE/SHE DEEMS NECESSARY IN MY CASE. I FURTHER AUTHORIZE HIM/HER TO DISCLOSE ALL OR PART OF MY (PATIENTS) RECORDS TO ANY PERSON OR CORPERATION WHICH IS OR MAY BE LIABLE UNDER CONTRACT TO THE CLINIC OR TO THE PATIENT OR TO A FAMILY MEMBER OR EMPLOYER OF THE PATIENT FOR ALL OR PART OF THE CLINIC CHARGE, INCLUDING BUT NOT LIMITED TO HOSPITAL FOR MEDICAL SERVICES COMPANY, INSURANCE COMPANY, WORKER'S COMPENSATION CARRIERS, WELLFARE FUNDS, OR THE PATIENT'S EMPLOYER.

PATIENT INFORMATION CONSENT: I UNDERSTAND THAT BLUE MOUNTAIN CLINIC MAY NEED TO USE AND DISCLOSE INFORMATION ABOUT MY HEALTH OR MEDICAL PROBLEMS FOR THE PURPOSE OF ARRANGING, CONDUCTING, OR REFERRING MY TREATMENT, FOR OBTAINING PAYMENT OF SERVICES, AND FOR THE PURPOSES OF OPERATING THE PRACTICE. I CONSENT TO THE USE OF MY INFORMATION FOR THE PURPOSED OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS. I AUTHORIZE BLUE MOUNTAIN CLINIC TO OBTAIN/HAVE ACCESS TO MY MEDICAL HISTORY.

I UNDERSTAND THAT MY CONSET IS NOT NEEDED IF THE LAW REQUIRES BLUE MOUNTAIN CLINIC TO REPORT SOME ASPECT OF MY PROTECTED HEALTH INFORMATION TO A GOVERNMENT AGENCY (FOR EXAMPLE SUSPECTED ABUSE, COMMUNICABLE DISEASE, AND POTENTIAL BODILY HARM TO MYSELF OR OTHERS).

I UNDERSTANDTHAT I HAVE A RIGHT TO REVIEW THE BLUE MOUNTAIN CLINIC PRIVACY NOTICE, TO REQUEST RESTRISTCTIONS BE PUT ON THE USE OF MY INFORMATION AND REVOKE MY CONSENT AT A LATER DATE IN WRITING.

I UNDERSTAND THAT IF I WITHHOLD CONSET FOR THE USE OF MY MEDICAL INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT OR OPERATIONS, BLUE MOUNTAIN CLINIC MAY REFUSE TO UNDERTAKE MY CARE.

I, AND THE UNDERSIGNED, HEREBY CONSENT TO THE FOLLOWING TREATMENT: ADMINISTRATION AND PERFORMANCE OF ALL TREATMENTS, ADMINISTRATION OF ANY NEEDED ANESTHETICS, ADMINSTRATION OF ANY CDC RECOMMENDED VACCINATIONS, PERFORMANCE OF SUCH PROCEDURES AS MAY BE NECESSARY OR ADVISABLE IN THE TREATMENT OF THIS PATIENT, USE OF PRESCRIBED MEDICATIONS, PERFORMANCE OF DIAGNOSTIC PROCEDURES/TESTS, CULTURES, BIOPSIES AND SURGERY, PERFORMANCE OF OTHER MEDICALLY ACCEPTED LABORATORY TESTS THAT MAY BE CONSIDERED MEDICALLY NECESSARY OR ADVISABLE BASED ON THE JUDGEMENT OF THE ATTENDING PHYSICIAN OR THEIR ASSIGNED DESIGNEE. I FULLY UNDERSTAND THAT THIS IS GIVEN IN ADVANCE OF ANY SPECIFIC DIAGNOSIS OR TREATMENT. I INTEND THIS CONSENT TO BE CONTINUING IN NATURE EVEN AFTER SPECIFIC DIAGNOSIS HAS BEEN MADE AND TREATMENT RECOMMENDED. THE CONSENT WILL REMAIN IN FULL FORCE UNTIL REVOKED IN WRITING.

I UNDERSTAND THAT BLUE MOUNTAIN CLINIC MAY REFUSE CARE DUE TO NO SHOWS, LACK OF PAYMENT, DISRESPECT TO STAFF, OR DESTRUCTION/THEFT OF PROPERTY.

MEDICARE PATIENTS: I AUTHORIZE TO RELEASE MEDICAL INFORMATION ABOUT ME TO THE SOCIAL SECURITY ADMINSTRATION AND ITS INTERMEDIARIES FOR MY MEDICARE CLAIMS. I SIGNED THE BENEFITS PAYABLE FOR THE SERVICES TO BLUE MOUNTAIN CLINIC.

HIPPA ACKNOWLEGMENT: I HAVE RECEIVED AND READ THE BLUE MOUNTAIN CLINIC NOTICE OF PRIVACY PRACTICES. IN MY ABSENCE OR FOR THE BENEFIT OF GAINING MEDICAL ADVICE ON MY BEHALF, I AUTHORIZE THE BELOW LISTED PERSON(S) TO GAIN PATIENT HEALTH INFORMATION FOR OR WITH ME.

Do we have your permission to :

Leave a message on your answering machine or cell phone?	**❑ YES**	**or**	**❑ NO**
Contact you via text message?	**❑ YES**	**or**	**❑ NO**
Contact you via email?	**❑ YES**	**or**	**❑ NO**
Enter you immunization records into the state vaccine system (imMTrax)	**❑ YES**	**or**	**❑ NO**

I certify that I have read and fully understand the above statements and consent voluntarily to its content. I certify that all information provided above is true and correct to my knowledge.

_____

Patient (or Guardian) Signature DATE

Blue Mountain Clinic
Phone: 406-721-1646
Fax: 406-543-9890
610 N California St. Missoula, MT 59801

Legal Name (please include middle initial and maiden name) BirthDate:_____

_____

Preferred pharmacy: _____

What are your current health goals?_____

_____

Medical History:

Respiratory: Lung/Sinus problems, Asthma _____

Cardiac: High Blood Pressure, Heart Murmur,

High Cholesterol, Blood Clotting disorder _____

Gastrointestinal Problems: Liver, Stomach,

Gallbladder, Bowel, Heartburn _____

Joint Problems: Pain, Swelling, Injury Arthritis _____

Genital/Urinary Problems: Bladder, STD's

Kidney, Sexual Function, Other _____

Hormonal: PMS, Diabetes, Thyroid, Other _____

Neurologic: Migraines, Seizures, Other _____

Psychologic: Depression, Anxiety, Other _____

Illness, Injuries, Surgeries, Hospitalizations: _____

Allergies:_____

Surgeries:

Surgery/year _____ Surgery/year _____

Surgery/year _____ Surgery/year _____

Family History: Check and write relationship of relative

❑ Alcohol abuse	❑ Depression	❑ Cancer other:
❑ Alzheimer's	❑ Diabetes	❑ Seizure disorder
❑ Anxiety	❑ Liver Disease	❑ Aortic Aneurysm
❑ Asthma	❑ High cholesterol	❑
❑ Stroke	❑ High blood pressure	❑
❑ COPD	❑ Hyper/Hypothyroidism	❑
❑ Heart attack/CAD	❑ Colon Cancer	❑
❑ DVT/blood clot	❑ Breast Cancer	❑

Medications:_____

_____

Adult Social History	Pediatric Social History 0-17
Preferred Name:	Preferred Name:
Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed ❑ Partner	Parent's Names:
Spouse's Name:	Siblings Names:
Children's Names:	Anyone else patient lives with:
Hobbies:	Grade Level:
Diet: ❑ Regular ❑ Vegetarian ❑ Vegan ❑ Gluten-free ❑ Low Carb ❑ Other (specify)	Name of school:
Exercise: ❑ None ❑ Rare ❑ 1-2 days/week ❑ 3-4 days/week ❑ 5-7 days/ week	Hobbies/Sports:
Alcohol Use: ❑ None ❑ Rare ❑ Occasional ❑ Daily- number of drinks/day:	Have you ever smoke tobacco? ❑ Never ❑ Former ❑ Current
Illicit drug use (either past or present):	Have you ever vaped? ❑ Never ❑ Former ❑ Current
Marijuana Use (medical or recreational): ❑ None ❑ Rare ❑ 1-2 days/week ❑ 3days/week ❑ Daily	Have you ever chewed tobacco? ❑ Never ❑ Former ❑ Current
Total cups of coffee, tea, soda per day:	What is child's home situation? ❑ Mother ❑ Father ❑ Split houses ❑ Other
Do you/have you ever smoked tobacco? Have you ever smoke tobacco? ❑ Never ❑ Former ❑ Current How many year have/did you smoke? _____ What age did you start smoking? _____ How much do you currently smoke? _____ What year did you quit smoking? _____	Is child passively exposed to smoke? ❑ Yes ❑ No Are there any smoker in your house? ❑ Yes ❑ No
Do you/ have you ever vaped? ❑ Never ❑ Former ❑ Current How many years have/did you vape? _____	Parent's Marital Status: : ❑ Married ❑ Single ❑ Separated ❑ Divorced ❑ Widowed
Do you/ have you ever chewed? ❑ Never ❑ Former ❑ Current How many years have/did you chew? _____	Gender Identity: ❑ Female ❑ Male ❑ Other: (Please specify):_____
Are you passively exposed to smoke? ❑ Yes ❑ No	Assigned sex at birth: ❑ Female ❑ Male
What is highest level of education reached?	Sexual orientation: ❑ Homosexual ❑ Heterosexual ❑ Bisexual ❑ n/a ❑ Other:_____
Are you currently in school? ❑ Yes ❑ No	
What is your occupation?	
Are you able to walk? ❑ Yes ❑ No Do you use: ❑ Cane ❑ Walker ❑ Wheelchair	If Applicable:
Are you at risk for STI ? ❑ Yes ❑ No Are you sexually active? ❑ Yes ❑ No Do you use protection during sex? ❑ Always ❑ Usually ❑ No	Are you at risk for STI ? ❑ Yes ❑ No Are you sexually active? ❑ Yes ❑ No Do you use protection during sex? ❑ Always ❑ Usually ❑ No
Do you have an advanced directive? ❑ Yes ❑ No	
Do you have a medical power of attorney? ❑ Yes ❑ No	
Gender Identity: ❑ Female ❑ Male ❑ Other: (Please specify):_____	
Assigned sex at birth: ❑ Female ❑ Male	
Sexual orientation: ❑ Homosexual ❑ Heterosexual ❑ Bisexual ❑ n/a ❑ Other:_____	