St. Vincent
Frontier Cancer Center
a St. Vincent Healthcare Facility

PO Box 30976 • Billings, Montana 59107 • 406-238-6290 • Fax 406-238-6280

PATIENT INFORMATION

❑ NEW ❑ OFFICE UPDATE

Last Name _____ First Name _____ MI _____

Street Address _____ PO Box _____

City _____ State _____ Zip Code _____

SEX: ❑ M ❑ F Employed ❑ Yes ❑ No ❑ Student ❑ Retired

Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Declined Race: ❑ Black ❑ White ❑ Asian ❑ Native American ❑ Declined

Employer _____ Work Phone # _____

Home Phone # _____ Cell # _____

Date of Birth _____ Social Security # _____

Marital Status: ❑ S ❑ M ❑ W ❑ D Name of Spouse _____ Spouse's Day Phone # _____

Emergency Contact *(Other than spouse)* _____ Day Phone # _____

Relationship: _____

Patient Email Address: _____

Name of Primary Care Physician _____

PERSON RESPONSIBLE FOR PAYMENT *(IF OTHER THAN PATIENT):*

Last Name _____ First Name _____ MI _____

Address (if other than patient) _____

INSURANCE INFORMATION

PLEASE HAVE RECEPTION TAKE A COPY OF YOUR CARD(S): ❑ INSURANCE CARDS COPIED ❑ NO INSURANCE

If your insurance is under your spouse's name or other family member, you MUST supply a Social Security Number and a Date of Birth for the card holder.

_____
CARDHOLDER (NAME OF SUBSCRIBER) *RELATIONSHIP TO PATIENT*

_____
DOB OF SUBSCRIBER *SSN OF SUBSCRIBER*

_____
EMPLOYER OF SUBSCRIBER *EFFECTIVE DATE OF COVERAGE*

I accept responsibility for payment in full of my medical services and hereby authorize all Insurance benefits to be paid directly to St. Vincent Frontier Cancer Center. I also authorize release of medical Information necessary to process Insurance claims.

_____
*****SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE* *DATE*

WRITTEN ACKNOWLEDGMENT

I acknowledge that I have received a copy of St. Vincent Frontier Cancer Center's Notice of Privacy Practices, which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I request.

_____
*****SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE* *WITNESS*

_____
DATE *DATE*

PATIENT COMMUNICATION REQUEST

To respect your privacy, please tell us how you would like us to communicate with you regarding your healthcare, e.g., test results, appointment changes, surgery schedule, etc.:

If you are not there to take our call, do you want us to leave a message?

Home: ❑ YES ❑ NO
Work: ❑ YES ❑ NO
Cell: ❑ YES ❑ NO

****Are there family members or friends to whom we may disclose your health care information?
❑ YES ❑ NO

If yes, please list their relationship, names and phone numbers, if known:

NAME RELATIONSHIP PHONE: *MAY WE LEAVE A MESSAGE?* ❑ YES ❑ NO

NAME RELATIONSHIP PHONE: *MAY WE LEAVE A MESSAGE?* ❑ YES ❑ NO

NAME RELATIONSHIP PHONE: *MAY WE LEAVE A MESSAGE?* ❑ YES ❑ NO

NAME RELATIONSHIP PHONE: *MAY WE LEAVE A MESSAGE?* ❑ YES ❑ NO

RELEASE OF INFORMATION TO OTHERS

By signing this form, I understand that I am authorizing St. Vincent Frontier Cancer Center to disclose health care information to the person(s) listed above, that I can revoke this authorization in writing, and doing so will stop future use or disclosure of this information. I understand you will act on this authorization until I revoke that authority.

*****SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE* DATE