EAGLE CREEK FAMILY MEDICINE
1281 E. IRON EAGLE DR. EAGLE, IDAHO 83616
PHONE: (208) 939-5535 FAX: (208) 939-5536

(Please Print)

PATIENT REGISTRATION INFORMATION

Last Name:	First:	Middle:	Marital status: (circle one) Single / Mar / Div / Sep / Wid

Date of Birth: _____/_____/__________	Sex: ☐ M ☐ F	Home Phone #: ( ) Cell Phone #: ( ) Work Phone #: ( )	Preferred Method of Contact for Reminder Calls : (please circle one) VOICE OR TEXT

Physical Address:	City:	State:	Zip code:

Email Address:	Social Security #:

Preferred Pharmacy :	Can we leave a message regarding your medical care and test results? (please circle one) **YES** **NO**

Occupation:	Employer:

Ethnicity (please select one) : ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Race (please select): ☐ White ☐ Hispanic ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ Asian ☐ American Indian/ Alaska Native ☐ Other ☐ Decline

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: ___/___/_____	Address (if different):	Home phone #: ( )

Occupation:	Employer:	Employer address:	Employer phone #: ( )

Subscriber's name:	Subscriber's S.S. no.:	Birth date: ___/___/_____	Group no.:	Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	Co-payment:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

I certify that I have read and agree to Eagle Creek Family Medicine's (ECFM) payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to ECFM all money to which I am entitled for medical expenses related to the services performed from time to time by ECFM, but not to exceed my indebtedness to ECFM. I authorize ECFM to release medical information to my insurance carrier or third party payer to facilitate processing of my insurance claims. I understand failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. **A $35.00 returned check fee will be charged for checks returned due to insufficient funds.** I chose to receive communication from ECFM by voice, text or mail at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such voice and texts may not be secure and there is a risk that they may be read by a third party.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to ECFM. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits payable for related services.

Patient Signature ____________________________________ **Date**________________