



213 N. Main St, Moscow, ID 83843  
Telephone: 208-882-7565 Fax: 208-882-7567

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

PREFERRED PROVIDER  Jordan Harlow  Sara Presol  Jessica Cruz or  No Preference

Mailing Address: \_\_\_\_\_

(All correspondence will be sent to this address)

Physical address (if different than mailing): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Number: \_\_\_\_\_

Social Security#: \_\_\_\_\_ (government policies) Gender at Birth:  Male  Female

Gender Identity:  Male  Female  Transgender: MTF or FTM (circle one)  Nonbinary

Email Address: \_\_\_\_\_

(By providing your email, you agree to be enabled for our Online Patient Portal)

Marital Status:  Single  Married  Divorced  Widowed  Separated  Other: \_\_\_\_\_

Race:  White  Asian  Black  American Indian  Native Hawaiian  Other: \_\_\_\_\_

Ethnicity:  Non-Hispanic  Hispanic Origin  Unknown

Preferred Language:  English  Spanish  Mandarin  Russian  Hindi  Other: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_

**Disclosure of Information**

I, the undersigned, give Moscow Medical, their staff, and the provider permission to disclose information about my care, diagnosis, and treatment to the persons listed. I understand that these person(s) will be asked to provide identification before releasing any information. I acknowledge that this release does not compel Moscow Medical or its associates to release my health information. I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I release Moscow Medical and its staff from all the legal responsibility or liability that may arise from the release of this information. This consent will remain in force until revoked by me in writing.

Contact \_\_\_\_\_ Relation \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone Number: (\_\_\_\_\_) \_\_\_\_\_

Contact \_\_\_\_\_ Relation \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone Number: (\_\_\_\_\_) \_\_\_\_\_

I authorize payment to be made to either Moscow Medical or myself. If my health insurance requires authorization from the insurance company or another physician and, for whatever reason, Moscow Medical does not receive authorization, I agree to accept full financial responsibility. Moscow Medical has permission to provide my insurance company with all the information necessary to make the correct payment. I understand that I am responsible for all charges incurred. Accounts are due within 30 days of the date of service.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Emergency Contact:**

\_\_\_\_\_ Phone Number: \_\_\_\_\_ Relation: \_\_\_\_\_

**Insurance Information**

**Primary Insurance:** \_\_\_\_\_

Subscriber ID: \_\_\_\_\_ group#: \_\_\_\_\_

Policyholder (If different than patient): \_\_\_\_\_

DOB: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Policy holder's address: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

Subscriber ID: \_\_\_\_\_ group#: \_\_\_\_\_

Policyholder (If different than patient): \_\_\_\_\_

DOB: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Policy holder's address: \_\_\_\_\_

**Whom may we discuss your account/billing information with?**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

**For Minors:**

Guarantor: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name(s) of legal guardian(s) for the patient: \_\_\_\_\_

Do any non-guardians have permission to bring patient(s) in for visits? If yes, list and sign below

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Signature of Guardian: \_\_\_\_\_

**How did you hear about us?** (friend, Facebook, radio, etc): \_\_\_\_\_