MOSCOW MEDICAL
where you matter

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

Patient Name: _____ **Date of Birth**: _____

Mailing Address: _____
(All correspondence will be sent to this address)
Home Phone: _____ **Cell**: _____ **Work**: _____

Gender: ☐Male ☐Female ☐Transgendered **Social Security#** (Required for government issued insurances):_____

Email Address: _____ **Employer**: _____
(By providing your email, you agree to be enabled for our Online Patent 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 ☐Chinese ☐Russian ☐Indian ☐Other:_____

Emergency Contact:
_____ Phone Number: _____ Relation: _____

Preferred Pharmacy: _____ Location: _____

Disclosure of Information

I, the undersigned, give Moscow Medical, their staff, and provider's permission to disclose information about my care, diagnosis, and treatment to the persons listed. I understand that these persons will be asked to provide identification before any information will be released. I acknowledge that this release does not compel Moscow Medical or any of 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 that 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 all information necessary to assist in making 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: _____

Relationship of Guardian: _____

Who may we discuss your account/billing information with?

Name: _____ Relation: _____

Insurance Information

Primary Insurance: _____

Subscriber ID: _____ group#:_____

Policy holder (If different than patient):_____

DOB: _____ Relation to patient: _____

Policy holder's address: _____

Secondary Insurance: _____

Subscriber ID: _____ group#:_____

Policy holder (If different than patient):_____

DOB: _____ Relation to patient:_____

Policy holder's address: _____

For Minors:

Guarantor: _____ Date of Birth: _____

Name(s) of legal guardian(s) for the patient: _____

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

Name: _____Relation:_____

Name: _____Relation:_____

Signature of Guardian: _____