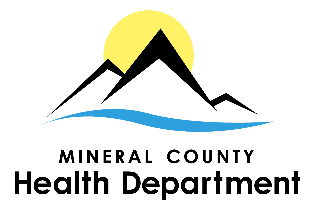
****

**Patient Face Sheet**

**Patient Information**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient’s Legal Name:** | | | | | | | | | | | |
| **Parent/Guardian Name** (if patient under 18): | | | | | | | | | | | |
| **Patient’s Date of Birth:** | | | | | **Age:** | | | **Gender:** | | | |
| **Race/Ethnicity:** | | American Indian/ Alaska Native | | Asian | | African American/Black | | Pacific Islander | Caucasian/White | | Hispanic |
| **Mailing Address:** | | | | | | | | | | | |
| **Email Address:** | | | | | | | | | | | |
| **Phone:** | Home: | | | | | | | Cell: | | | |
| **Preferred method of contact:** | | | Phone Call: | | | | Text Message: | | | Email: | |
| **Permission to leave a message?** | | | Yes: | | | | | No: | | | |

**Patient Insurance Information**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Select most appropriate form of insurance:** | | | | | |
| **None:** | **Healthy MT Kids (Medicaid):** | | **BlueCross BlueShield Healthy MT Kids:** | | **Private:** |
| **Does your insurance cover vaccines?** | | | | | |
| **Insurance Info:** | | Name of Insurance: | | | |
| ID: | | Group: | |
| **Subscriber Info:** | | Name: | | DOB: | |
| Relationship to patient: | | Employer: | |

**Appointment Information Verification** Review for accuracy and sign at each appointment

|  |  |  |
| --- | --- | --- |
|  | Signature | Date |
| I have reviewed the information on this Face sheet and confirm it is correct. |  |  |
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