Benefis
MISSOURI RIVER
MEDICAL CENTER

Patient Information (Please Print)

Name (Last, First, Mi.)_____

Birthdate:_____Soc. Sec. #:_____Gender: M /F Marital Status: S M W D

Mailing Address:_____City:_____State:_____Zip:_____

Physical Address (if different): _____

Telephone (Home):_____Cell:_____Work:_____

Email address:_____Language:_____Preferred method of contact:_____

Occupation:_____Employer:_____

Spouse's Name:_____Birthdate:_____Soc. Sec. #:_____

Parent/Guardian's Name (if patient is a minor):_____

Medication Allergies:_____Primary Care Provider:_____

Guarantor Information (Person Financially Responsible)

Name:_____Birthdate:_____Soc. Sec. #:_____

Mailing Address:_____City:_____State:_____Zip:_____

Physical Address (if different): _____

Telephone (Home):_____Cell:_____Work:_____

Occupation:_____Employer:_____

Relationship to Patient:_____

Persons to Contact in Case of an Emergency

Name:_____Relationship to Patient:_____

Telephone (Home):_____Cell:_____Work:_____

Physical Address:_____City:_____State:_____Zip:_____

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Insurance Information

Primary Insurance:_____Address:_____

Policy #:_____Group#:_____Effective Date:_____

Insured's Name:_____Birthdate:_____Soc. Sec. #:_____

Insured's Address:_____Phone:_____

Secondary Insurance:_____Address:_____

Policy #:_____Group#:_____Effective Date:_____

Insured's Name:_____Birthdate:_____Soc. Sec. #:_____

Insured's Address:_____Phone:_____

Statement of Financial Responsibility

I hereby agree to pay all the medical charges incurred by the above listed patient. I further understanding that these charges are my responsibility regardless of insurance coverage.

Signature:_____Date:_____

Printed Name:_____Relationship to Patient:_____

Consent for Treatment

(If patient is a minor or unable to sign, Parent or Legal Guardian complete section below)

I,_____, give Benton Medical Center permission to administer and /or order any medical treatment for,_____. I consent to the outpatient treatment for the patient named above. Authorization is here by granted to release this information to listed insurance company(s).

Signature:_____Date:_____

Printed Name:_____Relationship to Patient:_____