****

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