Flathead Valley Community College

Student Health Clinic

New Patient Registration Form

Last Name: First Name: Middle:
I have verified and updated, if necessary, my demographic information? Yes No
I am covered by either Medicare and/or Montana Medicaid? Yes No
If Yes, please provide your insurance card(s) so that they can be scanned into your electronic health record.

EMERGENCY CONTACT INFORMATION
Name of Emergency Contact: Relationship:
Phone Number (s):
Mailing Address: City: State: Zip Code:

CONSENT

Patient consents to the services that may be provided in connection with his/her outpatient treatment from FVCC Student Health Clinic which may include, but is not limited to, routine diagnostic procedures, nursing care, and other medical services provided to patient upon the instructions of patient's physician(s), and/or mid-level providers. Patient acknowledges that no guarantees have been made regarding the outcome of the care. If patient is unable to sign, consent for treatment is given by his/her duly authorized representative, or, in cases of emergency, shall be implied if such representative is not available.

AUTHORIZATION TO DISCUSS MEDICAL CARE

I _____ give my authorization to the FVCC Student Health Clinic to discuss my medical care with the following person (s). I understand this authorization will stay in effect until I ask to have it removed in writing.

Individual (s) Name:	Relationship to Patient:
_____	_____
_____	_____
_____	_____

Printed Name:_____

_____ **Date:** _____

Patient Signature/Authorized Representative