Flathead Valley Community College

Student Health Clinic

New Patient Registration Form

Last Name **First Name** **Middle**

I have verified and updated, if necessary, my address 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**

Mailing Address: **City** **State** **Zip** **Phone number**

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

The Montana Department of Public Health and Human Services (DPHHS) has requested that we seek your consent to share your/your child's immunization data with the DPHHS Immunization Information System (IIS). DPHHS may release IIS data to other public health agencies as well as to your/your child's healthcare providers to assist in your/your child's medical care and treatment. In addition, DPHHS may release IIS data to schools in order to comply with immunization requirements. Also, if you do not check the "I Opt In" box at this time, you can always choose to opt out at a later time and/or have your/your child's immunization record removed at any time by contacting your county's health department. You understand that any such revocation will be not effective as to uses and/or disclosures already made in reliance upon this authorization.

THIS IS NOT A CONSENT TO RECEIVE ANY IMMUNIZATION, IT IS ONLY A CONSENT TO REPORT YOUR/YOUR CHILD'S IMMUNIZATION DATA TO THE DPHHS IIS. Therefore, if you do not check the "I Opt In" box, we will collect and enter your/your child's immunization records into the DPHHS database.

☐ YES, I OPT OUT OF THE DPHHS IMMUNIZATION SYSTEM

Printed Name: _____ **Signature:** _____ **Date:** _____