EMERGENCY RESPONDERS HEALTH CENTER

Patient Information

First Name ______________________ Last Name________________________ Middle ___________

Date of Birth ___________________ SS# _________________________Gender: ☐ Male ☐ Female

Address ____

City ________________________ State ________________ Zip _____________

Email ____

Phone (Home) ________________ Phone (Cell) ________________ Phone (Work) _______________

Preferred Message/Contact Phone: ☐ Home ☐ Cell ☐ Work

Father's Name (if minor) ________________________________ Phone ________________________

Mother's Name (if minor) _______________________________ Phone ________________________

Insurance or Billing Information

Primary Insurance Name ____

Group Number _____________________________ ID Number ______________________________

Co-Pay $ __________________ Cardholder's Name ____

Secondary Insurance Name ____

Group Number _____________________________ ID Number ______________________________

Co-Pay $ __________________ Cardholder's Name ____

Employer: ____ **Phone:** ______________________

Address ________________________________ City _________________ St __________ Zip ______

Occupation: ____

Contacts

Emergency Contact: ____ Phone# __________________

Relationship ____

Preferred Pharmacy Name ____

Cross Streets ____ City: ________________________

Assignment of Benefits/Medical Release/Consent for Treatment

With this form (or a photo static copy of it) I authorize the release of any medical or other information acquired in the course of my treatment to my insurance company/third party payer, practitioners involved in my care at Emergency Responders Health Center: Dr. Robert J. Hilvers, M.D. and their agencies and to outside providers of my care. I understand that in the release of this information it may be transmitted via voice, hardcopy, fax, e-mail, electronic insurance send, phone transmission, or data line transmission. I authorize assignment of insurance/third party payer benefits to be paid directly to Robert J. Hilvers, M.D. / Emergency Responders Health Center 13960 W. Wainwright Boise, Idaho 83713 for all medical services rendered. I hereby give consent for medical treatment by Robert J. Hilvers, M.D. and /or Emergency Responders Health Center. I hereby consent to any medical treatment. X-ray, laboratory, echocardiography, or other procedures, which the physician may consider or advise in treatment of my case (or as legal guardian for patient). The signature on this form represents that I have read and agree to the above policy.

____ _____________________________________

Signature of Patient Date