Billings Clinic
Acorn Pediatrics

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Bozeman, MT 59718
406-522-5437

Fax 406-414-0274

Sheila Idzerda MD
Courtney Handlin DO
David White MD

Patient Registration

Tell us about the patient: (Please be sure to complete both sides of this form)

Last Name: _____First Name: _____MI: _____

Nickname: _____Age: _____ Date of Birth: _____

Address: _____

City: _____State: _____Zip: _____

Gender: Male Female

Which physician will be the patient's primary care provider? (Circle one)

Dr. Idzerda Dr. Handlin Dr. White Other:_____

Tell us about the family:

Parent 1: Last Name: _____ First Name: _____ MI: _____

Relationship to Patient: _____ Date of Birth: _____

Address: _____

City: _____State: _____Zip: _____

Phone (Home): _____Cell: _____Work: _____

Occupation: _____ Employer: _____

Parent 2: Last Name: _____ First Name: _____MI: _____

Relationship to Patient: _____ Date of Birth: _____

Address: _____

City: _____State: _____Zip: _____

Phone (Home): _____Cell: _____Work: _____

Occupation: _____Employer: _____

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Will insurance be used for today's visit?

- No. The visit will be paid for today.
- Yes. Please provide the receptionist with your insurance card. If you are covered by multiple insurance plans, indicate which is primary, secondary, etc.

Policy Holder: _____Date of Birth: _____

Billings Clinic Acorn Pediatrics accepts most major insurance plans. Check with the receptionist for more information.

Race:

- White (Not Hispanic or Latino)
- Hispanic or Latino
- Black, African American, Negro
- Native American Indian
- Asian
- Pacific Islander/ Native Hawaiian
- I prefer to leave blank
- Multi-Racial
- Other

Ethnicity:

- Assiniboine
- Blackfeet
- Chinese
- Chippewa
- Chippewa-Cree
- Crow
- Flathead Salish
- German
- Gros Ventre
- Hispanic or Latino
- Japanese
- Kootenai
- Non-Hispanic or Non-Latino
- Northern Cheyenne
- Other
- Shoshone
- Sioux
- Vietnamese

_____

By signing below, I am confirming that I understand and consent to the assignment of benefits, payment responsibility, treatment(s), and disclosures above.

Patient Name: _____Date: _____

Parent or Guardian Signature: _____

Relationship to patient: Parent Guardian Other _____