Patient Intake Form

Patient Last Name (Please Print)	First Name	Middle Initial

Date of Birth:	Gender: ◯ M ◯ F	Social Security Number:

Facility/Organization:	Service Start Date:	Room Number:

On-site Contact Person:

Insurance ID/Medicare Number:

Please include a copy of insurance card (both sides) if possible

Diagnoses:

Allergies:

Primary Caregiver:	Address:	Phone:

(Staff use only)

Packaging and Dispensing

☐ Dispill™ packaging (multi-med)	☐ 28 day cycle
☐ Single blister cards	☐ 14 day cycle
☐ Bottles	☐ Weekly cycle
☐ Other:_____	☐ Daily
	☐ Other:_____

Patient requires: ( ) Pick up ( ) Delivery
→See attached delivery form

Provider or representative signature:_____Date:_____

915 1st Ave. S STE 110
Great Falls, MT 59401

406-315-1989 Phone
406-315-1988 Fax

Payee Information

Patient Name:		**Date of Birth:**	
Payee Name:		**Relationship:**	
Address:	**City:**	**State:**	**Zip Code:**
Home Phone Number:		**Alternate Phone Number:**	
Emergency Contact:		**Emergency Phone Number:**	
Next of Kin/Guardian/POA:		**Next of Kin/Guardian/POA Phone Number:**	

Privacy Notice

I certify that I have received a copy of the privacy notice (HIPPA) and have reviewed the document. I acknowledge that Big Sky Managed Care, LLC is committed to protecting my health information.

Signature:_____Printed Name:_____
Date:_____

I understand that I am financially responsible to Big Sky Managed Care, LLC. for all charges incurred by the above-named patient, including copays, collection fees, etc. All non-covered medications and supplies will be billed to the patient or responsible party, unless prohibited by state regulations. All statement balances shall be paid in full unless other arrangements are made. I request that all mediations, now and in the future, be dispensed in a non-child resistant container.

Resident or Responsible Party: _____Date:_____

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