VALLEY INTERNAL MEDICINE & PEDIATRICS, P.C.

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PATIENT REGISTRATION FORM

New _____ Update _____ Account # Alert #

PATIENT INFORMATION

Patient Name (Last): ______________________ First: ______________________ Middle Initial: ___

Street Address: ______________________ City: ______________ State: _____ Zip Code: ______

Date of Birth: ______________ Age: ________ Sex: (circle one) **Male** **Female**

Home Phone: ( ) ______________ Business Phone: ( ) ______________ Ext: ______

Social Security Number: ____ - ____ - ____ Employer Name: ______________________

Employer Address & Phone: ____

Occupation: ______________________ E-Mail ______________________

Employment Status: (circle one) **Full Time** **Part Time** **F/T Student** **P/T Student** **Retired** **Unemployed**

Emergency Contact Name: ______________________ Address: ______________________

Home Phone: ( ) ______________ Business Phone: ( ) ______________ Ext: ______

Relationship to Patient: ______________________ Spouse or significant other ______________________

How did you hear about us? ____

RESPONSIBLE PARTY

Guarantor Name: ______________________ Relationship to Patient: **Insured** **Spouse** **Child** **Other**

Billing Address: ____

Date of Birth: ______________ Sex: **Male** **Female** Home Phone: ( ) ______________

Business Phone: ( ) ______________ Ext: ______ Social Security Number: ____ - ____ - ____

Employer: ______________________ Occupation: ______________________

Employment Status: **F/T** **P/T** **Retired** **Unemployed**

INSURANCE INFORMATION

Primary Insurance

Insurance Co Name: ______________________

Insurance Co Address: ______________________

ID Number: ______________________

Group Number: ______________ Co-pay: ________

Policy Holder Name (Subscriber): ______________________

DOB: ______________ Sex: **Male** **Female**

Relationship to Patient: **Insured** **Spouse** **Child** **Other**

Effective Date: ________ Expiration Date: ________

Employer: ______________________

Secondary Insurance

Insurance Co Name: ______________________

Insurance Co Address: ______________________

ID Number: ______________________

Group Number: ______________ Co-pay: ________

Policy Holder Name (Subscriber): ______________________

DOB: ______________ Sex: **Male** **Female**

Relationship to Patient: **Insured** **Spouse** **Child** **Other**

Effective Date: ________ Expiration Date: ________

Employer: ______________________

I hereby authorize payment directly to VALLEY INTERNAL MEDICINE & PEDIATRICS, P.C. for medical benefits, if any, otherwise paid to me for unpaid services rendered and the release of any information necessary to process claims for said services and authorization [illegible] records pertaining to my treatment to my insurance company or other 3rd parties responsible for payment of my medical charges including review activities related to my physician's participation with my health plan, via voice, electronic, mail or fax transmission. I [illegible] agree to pay all charges and/or co-payments at the time of service. In the event of default, I promise to pay all legal fees, collection costs and/or interest as may be required to effect collection of this note. This will also serve as an authorization for release of emergency department, urgent care and/or medical records which may be necessary in my medical care.

SIGNED (Patient or Responsible Party): ______________________ **DATE:** ______________