Valley Health Medical Group
Valley Health System

PATIENT REGISTRATION

PLEASE PRESENT YOUR DRIVERS LICENSE AND INSURANCE CARDS TO RECEPTION DESK

- **INSURANCE COPAYMENTS ARE EXPECTED BEFORE SERVICES ARE RENDERED.**
- **PAYMENT IN FULL IS EXPECTED WHEN SERVICES ARE RENDERED UNLESS WE PARTICIPATE WITH YOUR INSURANCE PLAN.**

HOW DID YOU HEAR ABOUT US? IS CONDITION: AUTO ACCIDENT RELATED? YES NO DATE OF INJURY:

GENERAL INFORMATION:

NAME ______________________________
Last Name First Name

HOME PHONE (____) ____-________

DATE OF BIRTH ______________ AGE ______

MARITAL STATUS: Married Single Divorced Widowed

e-mail address ______________________

SEX: M F S.S.# ______________________

IN CASE OF EMERGENCY, NOTIFY:

ADDRESS ______________________________

City State Zip Code

(Name) (Relationship)

(Phone)

EMPLOYER INFORMATION:

EMPLOYER NAME ______________________

EMPLOYER PHONE (____) ____-________

ADDRESS ______________________________

PATIENT OCCUPATION ______________________

City State Zip Code

IF PATIENT IS A MINOR (under age 18), COMPLETE INFORMATION FOR PARENT/GUARDIAN:

NAME ______________________________
Last Name First Name

EMPLOYER NAME ______________________

ADDRESS ______________________________

City State Zip Code

EMPLOYER ADDRESS ______________________

City State Zip Code

HOME PHONE (____) ____-________

EMPLOYER PHONE (____) ____-________

RELATIONSHIP TO PATIENT ______________________

PRIMARY INSURANCE:

INSURANCE CO. NAME ______________________

POLICYHOLDER ______________________

DATE OF BIRTH __________ SS# ______________

SECONDARY INSURANCE:

INSURANCE CO. NAME ______________________

POLICYHOLDER ______________________

DATE OF BIRTH __________ SS# ______________

CONSENT & RELEASE

- I understand that Valley Health Medical Group may release copies of my medical record and any other information necessary to facilitate my treatment, billing and claims submission, Valley Health Medical Group's operational procedures, which may include quality review, or these may be released to my employer and/or his insurer for work-related healthcare services.
- I authorize payment of medical benefits to Valley Health Medical Group from my insurance carrier if Valley Health Medical Group is a participating provider and/or I have an outstanding balance on my account.

Signed: ______________________________ Date: ______________