VALLEY SURGICAL GROUP

PATIENT REGISTRATION

PATIENT INFORMATION

SOCIAL SECURITY #_____

FIRST NAME_____MIDDLE_____

LAST NAME_____

SEX_____ DATE OF BIRTH_____/_____/_____

EMPLOYED_____ RETIRED_____ FULL STUDENT_____

EMPLOYER_____

DRIVER LIC #_____

REFERRING PHYSICIAN_____

HOME ADDRESS_____

_____

CITY_____STATE_____ZIP_____

EMAIL_____

HOME PHONE (_____)_____

WORK PHONE (_____)_____

CELL PHONE (_____)_____

HOW DID YOU HEAR OF US ?_____

INSURANCE INFORMATION

INSURANCE COMPANY_____

CARD NUMBER_____ GROUP NUMBER_____

INSURED PRIMARY CARD HOLDER'S NAME_____ RELATIONSHIP_____

DATE OF BIRTH_____/_____/_____ EMPLOYER_____

RETIRED_____

SECONDARY INSURNCE INFORMATION

INSURANCE COMPANY_____

CARD NUMBER_____ GROUP NUMBER_____

INSURED PRIMARY CARDHOLDER'S NAME_____RELATIONSHIP_____

DATE OF BIRTH_____/_____/_____ EMPLOYER_____

RETIRED_____

SPOUSE / GUARANTOR / RESPONSIBLE PARTY

SOCIAL SECURITY # _____ DATE OF BIRTH_____/_____/_____

RELATIONSHIP_____ DAYTIME PHONE (_____)_____

FIRST NAME_____MIDDLE_____ EMPLOYER_____

LAST NAME_____

ADDRESS _____ CITY_____STATE_____ZIP_____

Authorization to pay benefits to Physician: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services

_____

SIGNATURE (Patient or Parent if Minor) DATE

Authorization to release information: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

_____

SIGNATURE DATE

VALLEY SURGICAL GROUP

Patient Registration

Pharmacy Preferred

Name of Pharmacy:_____

Address: _____

_____

Phone Number: _____

I authorize treatment of the above patient.
I authorize the release of medical records necessary to process insurance claims.
I am responsible to pay for all services received, regardless of insurance coverage.
I authorize payment of medical benefits to be made directly to **Valley Surgical Group.**
I authorize the release of correspondence and/or medical records to other medical providers involved in my child's care.
I have read and understand the Financial policy.

Signature_____ Date_____