Patient Registration

Preferred Name: ______________________ **Today's Date:**___________________

Last Name: _____________________ **First Name:** ______________________ **MI**_____ **Sex: M / F**

DOB: _____/______/______**Social Security #:** _______-_______-________ **Marital Status: S/M/W/D**

Mailing Address: ______________________ **City:** ______________ **State:** _____ **Zip Code:** ________

CONTACT PHONE NUMBERS

Home: ___________________
Work: ___________________
Cell: ___________________
Primary:___________________

EMPLOYER

Company Name: ________________
Occupation: ______________________
Retired: Y/N Unemployed: Y/N

Preferred Communications: □ **Home Phone** □ **Cell Phone** □ **Work** □ **E-mail**

Preferred Pharmacy: ______________**Cross Streets:** _________________**City:**_______________

Emergency Contact: __________________ **Phone:** ________________ **Relationship:** _________

Additional Information

Preferred Language:____________________**E-mail address:**______________________________

Ethnicity: □ Hispanic or Latino **OR** □ Non- Hispanic or Latino

Race: □ **White** □ **Black or African American** □ **American Indian or Alaska Native**
□ **Native Hawaiian or Other Pacific Islander** □ **Asian** □ **Other Race**

Referring Physician: ___________________________________ **Phone:** ______________________

Primary Care Physician: _______________________________ **Phone:** ______________________

Specialty Clinic's – We're not your Primary Care Physician, you were Referred to our Office.
Does your Insurance Require a Referral for you to be seen? (Y/N) ____________

Insurance Coverage

Primary Insurance Plan: _________________**Primary Insured Name:** ______________________

Insured Relationship to patient: ___________________ (Are you the policy holder or is your spouse/parent (Parent, Legal Guardian, Spouse)

Insured ID Number: ________________________**Group Number:** ________________________

Insured Phone: ______________________________**Insured Soc. Sec :**______________________

Insured Date of Birth: _________________________**Insured Employer:** _____________________

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Secondary Insurance Plan: ________________**Secondary Insured Name**: __________________

Insured Relationship to patient: ___________________ (Are you the policy holder or is your spouse/parent (Parent, Legal Guardian, Spouse)

Insurance ID Number: ________________________**Group Number:** _______________________

Insured Phone: ______________________________**Insured Soc Sec #:**______________________

Insured Date of Birth: _________________________**Insured Employer**: _____________________

Is Today's Visit Associated With A Work Injury or Auto Accident? □ **YES** □ **NO**

Date of Injury: ____________________**Workers Comp/Auto Plan:** ________________________

WC/Auto Claim #: _____________________________**Adjuster Name:** ______________________

Address: ____**Phone:**______________________

I hereby authorize Platte Valley Medical Center – Clinic Support Services to treat the patient identified above. I acknowledge that I am responsible to pay charges for all treatments administered by the physician to the patient. I understand that insurance may not pay for all charges and I understand that I am obligated to pay for all charges not paid by insurance

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims.

No Show Notice to Patients: Please provide us with a minimum of 24 hours advance notice if you must cancel an appointment. In the event you do not provide this notice to our clinic, you will be charged a $25.00 no show fee.

Signature of Patient/Authorized Person: ________________________________**Date:**______________