

Cedar Valley Medical Specialists, P.C.
Patient Registration Form

Please Print

Date: _____

Name _____
FIRST MI LAST

Address _____

City _____ State _____ Zip Code _____ Home phone _____

Alternate Daytime Phone _____ Birthdate ____/____/____ Age ____ Sex: M ____ F ____

Social Security Number ____/____/____ Married ____ Single ____

Widowed ____

Referred By: _____ Family Dr: _____

Student: Yes ____ No ____ Retired: Yes ____ No ____ Working: Yes ____

No ____ If Working: _____

Employer Name _____ Phone _____

Employer Address _____

Spouses Name & Employer _____

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Company Name _____

Policy Holder _____ Policy Holders Date of Birth _____

Group #: _____ Policy #: _____ Policy Holders S.S.#: _____

Insured Employer _____ Relationship to patient _____

SECONDARY INSURANCE

Insurance Company Name _____

Policy Holder _____ Policy Holders Date of Birth _____

Group #: _____ Policy #: _____ Policy Holders S.S.#: _____

Insured Employer _____ Relationship to patient _____

If Patient is under 18 years of age: *(and you have not provided the following information in the Health Insurance section above)*

Father's Name _____ Employer _____

Address: _____ Home Phone _____

Mother's Name _____

Employer _____

Address: _____ Home Phone _____

If this visit is a result of an accident or injury, please answer the following questions & complete the accident/injury form.

Date of Accident or Injury _____ Brief Description of Injury _____

-
-
- I authorize you to give me reasonable and proper medical care by today=s standards.
 - I authorize Cedar Valley Medical Specialist's P.C. to release any medical information necessary to process my claim.
 - I authorize payment of medical benefits to Cedar Valley Medical Specialist's P.C.

- I understand that I am responsible for any balance due on my account.

Signature _____ Date _____

Revised 03/05/04