VALLEY WOUND HEALING CENTER

REGISTRATION FORM

(PLEASE PRINT)

Today's Date:__/___/____Referred By:_____ Primary Care:_____

PATIENT INFORMATION

Last Name:_____ First Name:_____ Middle:_____

Former Name:_____ Birth Date:____/____/_____ Age:_____ Sex: M / F

Marital Status (circle one): Single / Mar / Div / Sep / Wid Phone Number: _____

Street Address:_____ Social Security :_____

P.O. Box:_____City:_____State:_____Zip Code:_____

INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person responsible for bill:_____ Birth Date:___/___/____Home Ph:_____

Address (if different):_____

Is this patient covered by insurance? Yes / No

PRIMARY INSURANCE:_____ Subscriber's name:_____

Subscriber's S.S. No_____ Birth Date:___/___/___Group No:_____ Policy #_____

Co-payment: $_____ Relationship to subscriber: ___Self ___ Spouse ___Child ___Other

SECONDARY INSURANCE:_____ Subscriber's Name_____

Subscriber's S.S. No_____ Birth Date:___/___/___Group No:_____ Policy #_____

Patient's relationship to subscriber : ___Self ___Spouse ___Child ___Other

IN CASE OF EMERGENCY

Local friend or relative _____ Cell Phone Number _____Work Number_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize the release of any information required to process my claims.

Patient/Guardian Signature_____Date_____