Patient Registration

Patient Information

Patient's Name: Last_____ First _____Middle_____

Social Security #:_____-_____-_____ Male _____ Female _____ Date of Birth _____/_____/_____

Address: _____

City/State/Zip: _____ E-mail address: _____

Phone #: Daytime (____) _____-_____ Evening (____) _____-_____ Cell (____) _____-_____

Marital Status: ____ Divorced ____Married ____ Partner _____Single ____Widowed ____Legally Separated ____

Emergency Contact: _____ Phone: _____ Relationship to patient: _____

Insured Employer: _____ Plant Location: _____

Name of Pharmacy: _____Location: _____

Primary physician to release reports to: _____ Phone: _____

Living Will? Yes _____ No _____ Advanced Directive? Yes _____ No _____

Power of Attorney? Yes _____ No _____ Organ Donor? Yes _____ No _____

(Please provide a copy for chart)

Primary Insurance Information

Insurance Company Name: _____ Phone#: (____) _____-_____

Insurance Company Address: _____

Policy #: _____ Group #: _____

If patient is a MINOR, fill in responsible parent or guardian: (complete address if different from above)

Mother's Name: _____ Mother's Employer: _____
Mother's Date of Birth: _____/____/_____ Social Security # _____-____-_____ Work Phone: _____
Mother's address: _____ City/State/Zip _____

Father's Name: _____ Father's Employer: _____
Father's Date of Birth: _____/____/_____ Social Security # _____-____-_____ Work Phone: _____
Father's address: _____ City/State/Zip _____

(Please provide your insurance card and a picture ID to the front desk at check- in)

RELEASE OF MEDICAL INFORMATION

To whom may we, as your health care provider, release information about your medical condition?

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

I, the undersigned parent or legal guardian authorizes the following person(s) named below to sign for medical treatment for my child (ren) and to have legal authority in the case of my absence and incase of any medical emergency.

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

I hereby consent for Valentine Medical Center to release information to my employer certain records pertaining to my care such as:

_____ Labs
_____ X-rays
_____ Progress report
_____ Other: _____

Signature of Patient/Responsible Party: _____ **Date:** _____

I, the undersigned, or as the parent or legal guardian of the undersigned authorize Valentine Medical Center to render medical treatment to myself or the patient above for whom I am responsible.

Signature: _____ **Date:** _____