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

Please Print Date: ________________

Name

____
FIRST MI LAST

Address____

City ______________________________ State _________________ Zipcode _____________________

Home phone _____________________ Alternate Daytime Phone ________________________________

Birthdate ____/____/____ Sex: M ___F ___ Age ____ Married ____ Single ____ Widowed_____

Social Security Number ____/____/____ Referred By: ____

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

If Working:

Employer Name _______________________________________ Phone _____________________

Employer Address ____

Spouse=s Name & Employer____ Family Dr.: __________

HEALTH INSURANCE

PRIMARY INSURANCE

Insurance Company Name ____

Policy Holder _________________________________ Policy Holder=s Date of Birth ___________________

Group/Plan Number __________________________ Policy Number _____________________________

Insured Employer _________________________ Relationship to patient _____________________________

SECONDARY INSURANCE

Insurance Company Name ____

Policy Holder _________________________________ Policy Holder=s Date of Birth __________________

Group/Plan Number __________________________ Policy Number _____________________________

Insured=s 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 understand that I am responsible for any balance due on my account whether from an amount not fully covered by insurance or the charged amount if there is no insurance coverage. A payment plan will be set up if needed.

Signature ____ Date __________________

Form 107 Revised 10-28-96

INSURANCE AUTHORIZATION

Date ______________________________

I authorize Cedar Valley Medical Specialists, P.C. to release any medical information necessary to process my claim.

____
(Patient)

I authorize payment of medical benefits to Cedar Valley Medical Specialists, P.C.

____
(Policy Holder)

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MEDICARE AUTHORIZATION

Date ________________________________

I request that payment of authorized Medicare benefits be made either to me or in my behalf for any services furnished me by Cedar Valley Medical Specialists, P.C. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits for related services.

____________________________________	_______________________________________
(Patient)	(Medicare Number)

Form 168
revised 2/98