

**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 \_\_\_\_\_