



Patient Registration

Name: _____ Date of Birth: ____/____/____
FIRST MIDDLE LAST

Gender: Female Male Other: _____ SSN: _____

Race: _____ Ethnicity: _____ Marital Status: Single Married Divorced Widowed

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

May we leave messages from this office on your voicemail? Yes No

Email Address: _____

Emergency Phone: _____ Name: _____ Relationship: _____

If the patient is a minor, who may authorize treatment for the patient? _____

Relationship to Patient: _____ Phone: _____

If the patient is a minor, who is the financially responsible party? _____ Date of Birth: _____

Mailing Address: _____ Phone: _____

Please list anyone who might bring the patient to an appointment, relationship to the patient, and date of birth.

Please list any family members that are seen at Valley Allergy and Asthma Clinic. N/A

Preferred Pharmacy and Location (e.g. Fred Meyer in Palmer): _____

Who is your Primary Care Provider? _____ May we send records to your PCP? Yes No

I authorize this office to release to the named insurance company any information necessary to expedite insurance reimbursement. I understand that I am responsible for all charges regardless of insurance coverage.

I acknowledge that I have received a copy of the Notice of Privacy Practices.

By providing my email address and phone number above, I authorize this office to communicate with me via mobile phone, messages, email, and any kind of electronic communications, provided that these communications comply with privacy regulations.

Patient or Guardian Signature

Date

PRIMARY INSURANCE (Please provide card)

Insurance Name: _____ Relationship to Subscriber: _____

Subscriber's Name: _____ Subscriber's Date of Birth: ____/____/____

ID #: _____ Group #: _____ Subscriber's SSN: _____

SECONDARY INSURANCE (If applicable)

Insurance Name: _____ Relationship to Subscriber: _____

Subscriber's Name: _____ Subscriber's Date of Birth: ____/____/____

ID #: _____ Group #: _____ Subscriber's SSN: _____