VALLEY MEDICAL PRIMARY CARE, INC.

6611 Clyo Road, Suite E, Centerville, OH 45459
Phone: 937.208.8282 Fax: 937.208.8275

REGISTRATION FORM

PATIENT

FIRST NAME	M.I.	LAST NAME		

PATIENT'S SEX	AGE	BIRTHDATE	SOCIAL SECURITY NO.	MARITAL STATUS
☐ FEMALE ☐ MALE				☐ SINGLE ☐ MARRIED ☐ SEPERATED ☐ WIDOW

STREET ADDRESS	CITY	STATE	ZIP CODE

EMPLOYER	OCCUPATION	WORK PHONE	HOME PHONE

PRIMARY PHYSICIAN	RACE
	☐ CAUCASIAN ☐ ASIAN ☐ AFRICAN AMERICAN ☐ OTHER

RESPONSIBLE PARTY

FIRST NAME	M.I.	LAST NAME	DOB	SSN #

SEX	RACE	MARITAL STATUS
☐ FEMALE ☐ MALE	☐ CAUCASIAN ☐ ASIAN ☐ AFRICAN AMERICAN ☐ OTHER	☐ SINGLE ☐ MARRIED ☐ SEPERATED ☐ WIDOW

STREET ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	EMPLOYER'S NAME	EMPLOYER'S PHONE

EMPLOYER ADDRESS	CITY/ZIP

EMERGENCY CONTACT

NAME	PHONE NUMBER	RELATIONSHIP
NAME	PHONE NUMBER	RELATIONSHIP

INSURANCE COVERAGE

PRIMARY INSURANCE	EFFECTIVE DATE	POLICY HOLDER	ID NUMBER
POLICY HOLDER'S DOB	POLICY HOLDER SSN #	PATIENT RELATIONSHIP TO INSURED	EMPLOYER
		☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	
SECONDARY INSURANCE	EFFECTIVE DATE	POLICY HOLDER	ID NUMBER
POLICY HOLDER'S DOB	POLICY HOLDER SSN #	PATIENT RELATIONSHIP TO INSURED	EMPLOYER
		☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	

ADVANCED DIRECTIVES

DO YOU HAVE AN ADVANCED DIRECTIVE (LIVING WILL)?
☐ YES ☐ NO
IF YES, WHICH HOSPITAL IS IT FILED?

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MEDICARE PATIENTS ONLY – PLEASE COMPLETE THIS SECTION

1. Are you currently working? YES NO
   If YES, Employer ____
2. Do you have insurance through your employer? YES NO
3. Is your spouse currently working? YES NO
4. Do you have insurance through your spouse's employer? YES NO
5. Is your visit related to an accident or injury?
   If YES, do you have any other insurance responsibilities for this bill?

If you answered YES to any of the questions above, please provide insurance information to the staff