## VALLEY MEDICAL PRIMARY CARE, INC.

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

## **REGISTRATION FORM**

	FIRST NAME						M.I. LAST NAME							
	PATIENT'S SEX	BIRTHDATE SOC		CIAL SECURITY NO.		1	MARITAL STATUS							
PATIENT	□ FEMALE □ MALE	BIRTHDATE		30			SING	LE 🗆 MA		□ SEPERATED □ WIDOW				
	STREET ADDRESS				CITY			STATE		ZIP CODE				
Α														
	EMPLOYER		OCCUPATION			WORK PHONE				HOME PI	PHONE			
	DDIMARY BUNGIONAL				Lavor									
	PRIMARY PHYSICIAN		RACE	IANI 🗆 AG	MEDICANI	OTHER								
						□ CAUCAS	AN LAS	SIAN 🗆 /	AFRICAN A	WERICAN	OTHER			
	FIRST NAME		M.I. LAST NAI		T NAM	ME DO			OB SSN#					
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PARTY	SEX		RACE  □ CAUCASIAN □ ASIAN		ASIAN	N			MARITAL STATUS  SINGLE MARRIED SEPER			RATED		
	STREET ADDRESS	□ OTHER			CITY			□ WIDO	STATE ZIP CODE					
SIBI														
RESPONSIBLE	HOME PHONE	R'S NAME	'S NAME						EMPLOYER'S PHONE					
ES														
	EMPLOYER ADDRESS									CITY/ZIP				
EMERGENCY CONTACT	NAME PHONE NUMB					BER RELATIO			RELATION	NSHIP				
RGI NT	NAME			PHONE NUMBER				RELATIONSHIP						
EME														
	PRIMARY INSURANCE	ECTIVE DATE POLI			LICY HOLDER				ID NUMBER					
AGE	POLICY HOLDER'S DOB	POLICY HOLDER'S DOB POL			CY HOLDER SSN# PAT			TIENT RELATIONSHIP TO INSURED			EMPLOYER			
RANCE COVERAGE														
S						SELF SPOUSE CHILD O				HED				
NCE.	SECONDARY INSURANCE		ECTIVE DA	TE							IUMBER			
IRAI	SECONDARY INSURANCE		NIE	POLICY HOLDER				אשו	IUWBER					
INSU														
=	POLICY HOLDER'S DOB	LICY HOLDER SSN # PA			TIENT RELATIONSHIP TO INSURED			EMPLOYER						
					SELF SPOUSE CHILD OTHER									
- m	DO YOU HAVE AN ADVANCED DIRECTIVE (LIVING WILL)?													
CED	☐ YES ☐ NO  IF YES, WHICH HOSPITAL IS IT FILED?													
AN	I IF YES, WHICH HOSPITAL IS IT FILED?													
ADVANCED DIRECTIVES														

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MEDICARE PATIENTS ONLY – PLEASE COMPLETE THIS SECTION								
1.	Are you currently working? YES N	1O						
	If YES, Employer							
2.	Do you have insurance through your employer? Y	ES	NO					
3.	Is your spouse currently working? YES	NO						
4.	Do you have insurance through your spouse's employer?	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								