Cedar Valley Medical Specialists, P.C.
REGISTRATION FORM
(PLEASE PRINT)

Today's Date: _____

YOUR PHARMACY: _____

Address: _____

Patient Information (☐ **VALIDATED ID** ☐ **PHOTO ID REFUSED** ☐ **NO PHOTO ID AVAILABLE**)			
Last name:	First:	MI:	Sex: ☐ M ☐ F
Nickname:	Birth date:	Age:	Soc. Sec. #:

Marital status:	Primary Language:	Ethnicity:	Race: _____
☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed	☐ English ☐ Spanish ☐ Bosnian ☐ Other _____	☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Declined ☐ Unknown	01 = Black, African American 02 = Asian 03 = White 08 = American Indian, Alaska Native 09 = Native Hawaiian or Other Pacific Islander 98 = Unknown 99 = Declined

Address:	PO Box:	City:	State:	ZIP Code:

Home phone: ( )	Cell Phone: ( )	Email Address:

Referred by:	Family Doctor:

Emergency Contact Name:	Relationship:	Phone: ( )

Student Information:
☐ Not a Student ☐ Yes if yes, ☐ Full-time ☐ Part-time

College Name (If attending):

Employment Information: *(If employed fill out below)*
Full-time ☐ Part-time ☐ Retired ☐ Not Employed ☐

Occupation:	Employer:	Employer phone:

Spouse's Name:	Employer:

Who will be responsible for your account? ☐ **Self** (if self, skip to next section) ☐ **Spouse** ☐ **Father** ☐ **Mother** ☐ **Other**		
Name:	Soc. Sec.#	Phone:

Address (if different):	City:	State:	Zip Code:

Employer:	Business Phone:

Health Insurance Information (Please give your insurance card to the receptionist.)			
Primary Insurance:			
Insurance Company Name:		Group #:	Policy #:
Policy Holder:	Policy Holders Date of Birth:		Policy Holders S.S.#:
Insured's Employer:		Relationship to Patient:	
Secondary Insurance:			
Insurance Company Name:		Group #:	Policy #:
Policy Holder:	Policy Holders Date of Birth:		Policy Holders S.S.#:
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)*			
Father's Name:		Mother's Name:	
Address:	Phone:	Address:	Phone:
Employer:		Employer:	

If this is a result of an accident or injury, please answer the following questions & complete 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.
- I authorize that a copy of this information to be as valid as the original.

Signature: _____ Date: _____