Cedar Valley Medical Specialists, P.C
Patient Registration form

PATIENT INFORMATION:

Today's Date: _____

Patient Name: _____   Patients Date of Birth: _____

Email Address: _____   Social Security Number: _____

Patient's Phone #: _____   Occupation: _____

Patient's Employer _____   Employer Ph #: _____

Employment Status: ☐ Full Time   ☐ Part-time   ☐ Retired   ☐ Not Employed

Patient is the Insurance Policy Holder: ☐ Yes   ☐ No

If someone other than the patient is the Policy holder please complete the following:

Policy holder Name: _____   Date of Birth: _____

Social Security Number: _____   Relation to patient: _____

Address: _____   Phone Number: _____

City, State, zip: _____

Policy Holder's Employer: _____   Occupation: _____

Employed Full Time?:   ☐ Yes   ☐ No

LEGAL GUARDIAN INFORMATION: **COMPLETE IF PATIENT IS A MINOR**

Father's Name: _____   Mother's Name: _____

Father's DOB _____   Mother's DOB _____

Address: _____   Address: _____

City, State, Zip _____   City, State, Zip: _____

Phone Number: _____   Phone Number: _____

Employer: _____   Employer: _____

Occupation: _____   Occupation: _____

OR

Legal Guardian Name: _____

Guardian's DOB _____   Employer: _____

Address: _____   Occupation: _____

City, State, Zip _____

Phone Number: _____

RESPONSIBLE PARTY

Responsible Party for Payment: ☐ Self   ☐ Mother   ☐ Father   ☐ Legal Guardian

EMERGENCY CONTACT:

Name: _____   Relationship: _____

Phone Number: _____

I GIVE PERMISSION TO RELEASE PATIENT PERSONAL HEALTH INFORMATION TO THE FOLLOWING PEOPLE:

Name: _____   Relationship: _____   Phone #: _____

Name: _____   Relationship: _____   Phone #: _____

By my signature below:

- I authorize Cedar Valley Medical Specialists (CVMS) to give me reasonable and proper medical care by today's standards
- I authorize CVMS to release any medical information necessary to process my claim.
- I authorize Payment of medical benefits to CVMS
- I authorize that a copy of this information to be as valid as the original
- I understand that I am responsible for any balance due on my account.

Patient Signature: _____

Parent/Guardian Signature (for Minor Patient): _____