



Extraordinary people. Extraordinary care.

Vail Valley Medical Center

www.vvmc.com

# REGISTRATION FORM

(Please Print)

Clinic Name:		Today's date:		Account #:		
<b>PATIENT INFORMATION</b>						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Sex: <input type="checkbox"/> F <input type="checkbox"/> M	Birth date: / /	Social Security no.:		Home Phone:	Cell phone:	
Street address:		City/State:		Zip Code:		
P.O. Box:	City:	State:	ZIP Code:			
Occupation:	Employer:			Employer phone no.: ( )		
Chose clinic because/Referred to clinic by (please check one box):			<input type="checkbox"/> Dr.	<input type="checkbox"/> Newspaper	<input type="checkbox"/> Friend	
<input type="checkbox"/> Hospital	Primary Care Physician:					

<b>INSURANCE INFORMATION</b>					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:	Birth date: / /	Address (if different):		Home phone no.: ( )	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Occupation:	Employer:	Employer address:		Employer phone no.: ( )	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other

<b>IN CASE OF EMERGENCY</b>				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )