Valley Care Clinics

The care you need, when you need it

(**PLEASE PRINT**)

Last Name:_____**Birth/Maiden**_____ **First:**_____

Address:_____ **City:**_____ **ST:**___ **ZIP:**_____ **SSN:** ___-___-____

Home#_____ **Cell#**_____ **Work#**_____ **Ext#**_____

Employer/School Name:_____

Date of Birth:_____ **Married status:** __**Single** __**Married** __**Divorced** __**Separated** ___**Widowed**

Please check correct response

****If you do NOT want to provide the information please check "Declined"****

Race: ☐**Declined** ☐ **American Indian** ☐ **Asian** ☐**Black or African American**

☐**White** ☐ **Other**_____

Ethnic Group: ☐**Declined/Does not apply** ☐**Central American Indian**☐**Hispanic or Latino**

☐**Other**_____

Language: ☐**English**☐ **Spanish** ☐**Arabic** ☐**French** ☐**Other**_____

****Please select your PREFERRED METHOD of contact****

☐**Home**☐**Cell**☐**Work Phone**_____☐ **Email address**_____

☐ **Mail(address as listed above)**☐ **Other**_____

****Please select your PREFERRED METHOD to receive reminders from Valley Care Clinics****

☐**Home**☐**Cell**☐**Work Phone**_____☐ **email address**_____**N/A**_____

☐ **Mail(address as listed above)**☐ **Other**_____

Employer/School Name:_____

Name of Spouse/Partner:_____**Emergency Contact:**_____
Phone:_____ **Relation to Patient:**_____ **Address:**_____
City:_____ **ST:**____ **Zip**_____

Primary Insurance:

Employer/Organization:_____**Ins Comp:**_____ **Policy#** _____**Group#**_____

Policy Holder Name: _____**DOB**__/__/____ **Policy holder is:** ___**Self** ___**Spouse** ___**Parent**

Policy Holder Address:_____ **City**_____ **ST**____ **ZIP**_____

Secondary Insurance:

Employer/Organization:_____ **Ins Comp:**_____ **Policy#** _____**Group#**_____

Policy Holder Name:_____**DOB**___/___/_____ **Policy holder is:** ___**Self** ___**Spouse** ___**Parent**

Policy Holder Address:_____ **City**_____ **ST**____ **ZIP**_____

I understand that payment is due at the time service is rendered. I hereby authorize the release of any medical information to (1) an insurance company through which I claim benefits and (2) any physician involved in my medical care. I realize the authorization allows **Valley Care Clinics** to release any information to any of my insurers or physicians as requested by any such insurer or physician. I hereby assign all medical and/or surgical benefits to which I am entitled including Medicare, Private Insurance, Group Policy Benefits and Other Health Plans to **Valley Care Clinics**. I hereby agree to pay all costs and reasonable attorney fees in the event this account is turned over to an attorney for collection. I understand that I am financially responsible to **Valley Care Clinics** for all charges not covered, approved or considered necessary by my insurance company. I will pay at the time of service or have an agreeable payment arrangement set with the business office.

Signed:_____ Date:_____

As a courtesy to our patients we will file your insurance claims. Please help us by providing accurate information