

---

# NEW PATIENT REGISTRATION

VAILS FAMILY PRACTICE

PLEASE PRINT

Title Dr. Mr. Ms. Mrs. Miss Today's Date \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Suffix \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home (\_\_\_\_) \_\_\_\_\_ Pager (\_\_\_\_) \_\_\_\_\_

Work (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

Cell (\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_

SS# \_\_\_\_\_ Ethnicity \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Sex M F

Marital Status S M D W DP Sep \_\_\_\_\_ Name of Spouse/Partner \_\_\_\_\_

Has any member of your household been seen in this office? Y N Name \_\_\_\_\_

---

*If patient is a minor:*

Parent/Guardian's Name \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

---

*Person responsible for paying bill if other than patient:*

Parent/Guardian's Name \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ SS# \_\_\_\_\_

---

Primary Insurance \_\_\_\_\_

Name of Insured \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insured Person's Date of Birth \_\_\_\_\_

SS# \_\_\_\_\_

ID/Policy # \_\_\_\_\_

Group # \_\_\_\_\_

Secondary Insurance \_\_\_\_\_

Name of Insured \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insured Person's Date of Birth \_\_\_\_\_

SS# \_\_\_\_\_

ID/Policy # \_\_\_\_\_

Group # \_\_\_\_\_

*Person to contact in case of emergency who does not live with you:*

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_

Phone (H)(W)(C) \_\_\_\_\_

Last Primary Care Physician \_\_\_\_\_

Reason for transfer of care: \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_

Location \_\_\_\_\_

How did you hear about us? Referred by \_\_\_\_\_ Are they a Doctor / Patient / Friend?

- Article in Newspaper/Magazine     Flyer/Ad     Internet Search/VFP Website     Event \_\_\_\_\_
- Insurance Website     Insurance Directory     Assigned by Insurance     Physician Referral Hotline
- Hospital     Phone Book     Newspaper     Saw Sign     Other \_\_\_\_\_

I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS, TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INSURANCE AND ANY OTHER PLAN TO VAILS FAMILY PRACTICE. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS AND SECURE PAYMENT AND REQUEST THAT PAYMENT OF ALL BENEFITS BE MADE TO VAILS FAMILY PRACTICE. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY INSURANCE. IF AUTHORIZATION IS REQUIRED FOR THE VISIT BUT IS NOT ABLE TO BE OBTAINED, I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR PAYMENT. I AGREE TO PAY COLLECTION COSTS, ACTUAL ATTORNEY FEES, AND/OR COURT COSTS IN THE EVENT THAT LEGAL ACTION BECOMES NECESSARY TO ENFORCE THIS CONTRACT.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Date