

MOUNTAIN VALLEY MEDICAL CLINIC

PLEASE PRINT INFORMATION

PATIENTS NAME (12)	PATIENTS DATE OF BIRTH / /	M OR F	SOCIAL SECURITY# _____
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LOCAL MAILING ADDRESS _____ TOWN & STATE _____ ZIP _____ LOCAL PHONE _____

LOCAL 911 ADDRESS _____ TOWN & STATE _____ ZIP _____ LOCAL PHONE _____

MAILING ADDRESS (OUT OF AREA) _____ TOWN & STATE _____ ZIP _____ LOCAL PHONE _____

OCCUPATION OF PATIENT _____ PHONE (WORK) _____ OCCUPATION OF SPOUSE _____ PHONE (WORK) _____

NEXT OF KIN / NOTIFY IN EMERGENCY _____ RELATIONSHIP _____ PHONE _____

INSURANCE: Subscriber Name: _____ D.O.B.: _____
Primary: _____
Secondary: _____

PLEASE PROVIDE INSURANCE CARDS FOR FRONT DESK TO COPY

IF YOU DO NOT HAVE INSURANCE, would you like to be considered for a reduction of charges? YES _____ NO _____

I consent to treatment to the above named patient. Permission is hereby granted for the release of medical information necessary for the completion of insurance claim forms.

I understand that it is my responsibility to know my health insurance plan and that I am ultimately responsible for any charges related to my visit.

I hereby authorize and request all medical benefits other wise payable to me by the above named insurance, to be paid directly to the **Mountain Valley Medical Clinic**. I hereby release to your company or its representative, any information including diagnosis and the records of any treatment or examination rendered to me during the period of such medical care at the **Mountain Valley Medical Clinic**.

Signature (Authorized Person) Today's Date

IF YOU HAVE MEDICARE AND / OR MEDIGAP, PLEASE READ AND SIGN

I request that payment of authorized Medicare and / or Medigap benefits be made on my behalf to the **Mountain Valley Medical Clinic** for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Signature (Authorized Person) Today's Date