Timber Valley Medical Clinic

Patient Registration Form

Patient____
(Use Legal Name) Last First Middle Preferred Name

Address____
Street

______________________ ______________ ______________
City State Zip Code

SSN__________________ Birthdate__________________ Sex: M_____ F_____

Employer__________________________ Phone: Work__________ Home_________

Married_______ Single_______ Divorced_______

Responsible Party if other than Patient

Name____
Last First Middle

Address____
Street

______________________ ______________ ______________
City State Zip Code

SSN__________________ Birthdate__________________ Sex: M_____ F_____

Employer__________________________ Phone: Work__________ Home__________

Relationship to Patient____

Insurance

Primary__________________________ Group # ______________ I.D. #____________

Address____

Subscriber______________________________SSN#______________Birthdate_______
Last First Middle

Secondary__________________________ Group # ______________ I.D. #____________

Address____

Subscriber______________________________SSN#______________Birthdate_______
Last First Middle

Emergency Contact Person ______________________Phone: Home________ Work________

Authorization Information

The undersigned, as patient (or as parent or guardian of the patient), so hereby authorized the attending physician/practitioner to medically and/or surgically manage the treatment of the above named patient and to provide such surgical and/or medical treatment, which, in the physician/practitioners judgment, is deemed necessary for the benefit of the patient.

Signature____ Date______________