** PATIENT INFORMATION **

Name:		Social Security #		
Address:		City:	State:	Zip:
Home Phone: _		Cell Phone:	Business Pho	ne:
Age: I	Birthdate:	Circle: Male / Female	Circle: Single/Marrie	ed/Widowed/Divorced
Employer:		Occupation:		
Business Addre	SS:			_
Whom may we		you? ** INSURANCE INFORMA EASE PROVIDE CARD TO	TION **	
Primary Insurar	nce Company:			
Policy Holder:		Policy Holder Birthdate:	Relationship	to Patient:
Secondary Insu	rance Company:			
Policy Holder:		Policy Holder Birthdate:	Relationship	to Patient:
to Valley Diagnunderstand that I to release inform submissions.	d, certify that I (or my ostic Medical Center am financially respon action necessary to see	** ASSIGNMENT AND REI y dependent) have insurance cove all insurance benefits, if any, or nsible for all charges whether or no cure the payment of benefits. I au	rage with therwise payable to me of paid by insurance. I here ithorize the use of this si	reby authorize the doctor gnature on all insurance
Responsible Party		Kelatio	nship to Patient	Date