REGISTRATION FORM (PLEASE PRINT)

Your Pharmacy:_____

Address: _____

Buchanan County Health Center
Here For You. Trusted For Life.

Today's Date: _____

Patient Information (☐ VALIDATED ID ☐ PHOTO ID REFUSED ☐ NO PHOTO ID AVAILABLE)

Last name:	First:	MI:	Sex: ☐ M ☐ F
Nickname:	Birth date:	Age:	Soc. Sec. #:

Marital status:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Legally Separated
- ☐ Widowed

Primary Language:
- ☐ English
- ☐ Spanish
- ☐ Bosnian
- ☐ Other _____

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Non Hispanic or Latino
- ☐ Declined
- ☐ Unknown

Race:_____
- 01 = Black, African American
- 02 = Asian
- 03 = White
- 08 = American Indian, Alaska Native
- 09 = Native Hawaiian, Other Pacific Islander
- 98 = Unknown
- 99 = Declined

Address: PO Box: City: State: Zip Code:

Home Phone: ( ) Cell Phone: ( ) Email Address:

Referred by: Family Doctor:

Emergency Contact Name: Relationship: Phone: ( )

Student Information: ☐ Not a Student ☐ Yes if yes, ☐ full-time ☐ part-time

College Name (If attending):

Employment Information: (If employed fill out below) ☐ Full-time ☐ Part-time ☐ Retired ☐ Not Employed

Occupation: Employer: Employer phone:

Spouse's Name: Employer:

Who will be responsible for your account? ☐ **Self** (if self, skip to next section) ☐ **Spouse** ☐ **Father** ☐ **Mother** ☐ **Other**

Name: Soc. Sec.# Phone:

Address (if different): City: State: Zip Code:

Employer: Business Phone:

Health Insurance Information (Please give your insurance card to the receptionist.)

Primary Insurance:

Insurance Company Name: Group #: Policy #:

Policy Holder: Policy Holders Date of Birth: Policy Holders SS#:

Insured's Employer: Relationship to Patient:

Secondary Insurance:

Insurance Company Name: Group #: Policy #:

Policy Holder: Policy Holders Date of Birth: Policy Holders SS#:

Insured's Employer: Relationship to Patient:

If Patient is under 18 years of age: *(and you have not provided the following information in the Health Insurance Section)*

Father's Name:		Mother's Name:	
Address:	Phone:	Address:	Phone:
Employer:		Employer:	

If this is a result of an accident or injury, please answer the following questions & complete accident/ injury form.

Date of Accident or Injury: Brief Description of Injury:

- I authorize you to give me reasonable and proper medical care by today's standards.
- I authorize Cedar Valley Medical Specialist's P.C. to release any medical information necessary to process my claim.
- I authorize payment of medical benefits to Cedar Valley Medical Specialist's P.C.
- I understand that I am responsible for any balance due on my account.
- I authorize that a copy of this information to be as valid as the original.

Signature: _____ Date:_____