

VALLEY SURGICAL CLINICS, LTD.

3805 E. Bell Road, Suite 4800
Phoenix, Arizona 85032

Patient Registration

Patient Information:

Name: _____ (Please Print) Date of Birth: _____

Social Security # _____ Circle One: Male Female Marital Status (Circle One): M S W D

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Cell Phone Number: _____

Winter Visitors, please give local address: _____ City: _____ State: _____ Zip Code: _____

Name of Employer: _____ Work Phone Number: _____

Address of Employer: _____ City: _____ State: _____ Zip Code: _____

Primary Care Physician: _____ Phone Number: _____

Referring Physician: _____ Phone Number: _____

Reason for Today's Visit: _____

Is visit related to work or auto injury? Yes No Date of Injury: _____

Responsible Party Information (person who is the registered policy holder):

Name: _____ Relationship to Patient: _____

Date of Birth: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Employer: _____

Insurance Information:

Primary Insurance: _____ Phone #: _____

Group Number: _____ ID Number: _____

Secondary Insurance: _____ Phone #: _____

Group Number: _____ ID Number: _____

I understand that as a courtesy, Valley Surgical Clinics will submit claims directly to my insurance company(s). If, after my insurance company(s) have paid, and Valley Surgical Clinics has made all contractual adjustments per my insurance policy, I also understand that any unpaid balance will be my responsibility.

Signature: _____ Date: _____