VALLEY SURGICAL CLINICS, LTD.

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

Patient Registration

Name: ______________________________ Date of Birth: ______________
(Please Print)

In case of emergency, please notify (not living with you): ______________________________

Relationship to patient: ______________________________ Phone Number: ______________

To whom do you want your medical information released? Information will not be released until this person has been properly identified.

Name: ______________________________ Relationship to Patient: ______________

Identifying information (example: this person's date of birth/place of residence/social security number/age/phone number):

Identifying question: ______________________________ Correct Response: ______________

Name: ______________________________ Relationship to Patient: ______________

Identifying information (example: this person's date of birth/place of residence/social security number/age/phone number):

Identifying question: ______________________________ Correct Response: ______________

Name: ______________________________ Relationship to Patient: ______________

Identifying information (example: this person's date of birth/place of residence/social security number/age/phone number):

Identifying question: ______________________________ Correct Response: ______________

Signature: ______________________________ Date: ______________