



## NVVS PATIENT REGISTRATION FORM

\*Payment is due at time of service including co-pay, co-insurance, and/or unmet deductible. NVVS staff will collect at the time of service.

Patient Information					
Last Name, First MI		Social Security #	Date of Birth	Age	Sex M F
Current Address		Emergency Contact	Relationship	Phone#	
City State Zip		Referring Medical Provider Name			
Current Phone#	Cell Phone#	Referring Phone#			
Email address		Primary Physician Name			
Status: Single Married Widowed Divorced Separated		How did you hear about us (please be specific):			
Race: American Indian or Alaska Native Asian Black or African American Native Hawaiian or other Pacific Islander White Other Unspecified					
Ethnicity: Hispanic or Latino Not Hispanic or Latino Unspecified		Preferred Language:			
Employment Information					
Employment Status: FT PT DISABLED RETIRED OTHER		STUDENT STATUS: FT PT N/A			
Current Employer Name		Employer Address			
Occupation	Work Phone#	City State Zip			
Responsible Party Information					
Name		Social Security #	Date of Birth		
Address		Employer Name			
City State Zip		Work Phone#			
Phone#	Relationship to Patient: Self Spouse Parent/Guardian Other				
Insurance Information					
<b>Primary</b> Insurance Name		Subscriber ID#	Group#		
Claims Address		Subscriber Name			
City State Zip		Subscriber Social Security#	Subscriber Date of Birth		
Insurance Phone#		Relationship to Patient: Self Spouse Parent/Guardian Other			
<b>Secondary</b> Insurance Name		Subscriber ID#	Group#		
Claims Address		Subscriber Name			
City State Zip		Subscriber Social Security#	Subscriber Date of Birth		
Insurance Phone#		Relationship to Patient: Self Spouse Parent/Guardian Other			
<b>Third</b> Insurance Name		Subscriber ID#	Group#		
ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION					
I hereby authorize my insurance benefits to be paid directly to the provider for services rendered. I understand that my provider will bill my insurance on my behalf, but that I am financially responsible for all charges whether or not they are covered by insurance. I hereby authorize the release of all information necessary to secure the payment of benefits.					
Responsible Party Signature		Date			