VALLEY MEDICAL CENTER – CLINIC NETWORK
REGISTRATION FORM
(Please Print)

Office Use Only
Patient Note(s): ____________
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YOUR PREFERRED PHYSICIAN'S NAME: ___________________________________

PATIENT INFORMATION

LAST NAME: ____________________________ FIRST ____________________ MI ______ SSN#_____________________________

Sex: ☐ Male ☐ Female

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former or alternate name):

Mailing Address/Apt#	City:	State:	Zip:
Home Address (if different than mailing address)	City:	State:	Zip:

Home Phone:	Work Phone	Extension

Date of Birth Month_______Day_________Year____ Marital status: ☐Single ☐ Married ☐ Widow ☐ Separated ☐ Divorced

Racial Designation/Ethnicity: **OPTIONAL** information for Federal statistics, program administrative reporting, and civil rights compliance reporting only. Please mark one or more:
☐ ALASKAN NATIVE ☐ NATIVE AMERICAN ☐ ASIAN ☐ AFRICAN-AMERICAN or BLACK ☐ CAUCASIAN or WHITE ☐ HISPANIC or LATINO
☐ NATIVE HAWAIIAN ☐ PACIFIC ISLANDER ☐ MIXED RACE ☐ OTHER

Name of local friend or relative: (Not living at same address):	Relationship to patient:	Home phone no. ( )	Work phone no. ( )

LEGAL GUARDIAN
(If different from Responsible Party Below)

NAME: Last: ______________________________ First: ________________ MI: _______ Birth date: ______________

How did you hear about us? Mark one: ☐ Friend/Family Member ☐ Physician ☐ Physician Referral Line ☐ TV ☐ Radio ☐ Newspaper/Magazine ☐ Internet ☐ Attorney ☐ Special Event ☐ Other: _____________

Patient's Cell Phone__________________________ E-Mail Address____________________________Driver's License No _____________________

Employer	Occupation	Date Started

Employment Status (Age 18 & over) **Mark one**: ☐ Full time ☐ Part time ☐ Retired ☐ Not employed ☐ Self-employed ☐ Active Military Duty ☐ Student Status(Age 18-23 only): ☐ Full time ☐ Part time

(Person Responsible for payment of account if patient is under age 18)

RESPONSIBLE PARTY'S NAME: Last: ______________________________ First: ________________ MI: _______ Birth date: ______________

Patient's relationship to Responsible Party ☐ Spouse ☐ Child ☐ Other: ______________________	Is this person a patient here? ☐ Yes ☐ No	Home phone: ( )

Mailing/Billing Address:	City:	State:	Zip:

Employer's Name:	Employer address:	Employer phone: ( )

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

PRIMARY INSURANCE - Subscriber Information

Is this patient covered by insurance? ☐ Yes ☐ No (If no, please refer to Financial Policy)

Please indicate Primary Insurance CO	☐ AETNA ☐ CIGNA ☐ DSHS *(Please provide coupon)* ☐ FIRSTCHOICE ☐ MOLINA*(HO Please provide coupon and card)* ☐ MEDICARE ☐ PREMERA ☐ PACIFICARE/SECUREHORIZONS ☐ REGENCE ☐ UHC ☐ Other: ________________

Insurance Claims to Address	City	ST	ZIP
Subscriber's name: Last:___________________________ First: _________________	Subscriber SSN: – –	Patient's relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	

Birth date:	INS Effective Date	Group#:	Policy/ Identification #:	Co-payment: $

Subscribers Address (if different from patients):

	☐ AETNA ☐ CIGNA ☐ DSHS *(Please provide coupon)* ☐ FIRSTCHOICE ☐ MOLINA*(HO Please provide coupon and card)* ☐ MEDICARE ☐ PREMERA ☐ PACIFICARE/SECUREHORIZONS ☐ REGENCE ☐ UHC ☐ Other: ________________

Insurance Claims to Address	City	ST	ZIP
Subscriber's name: Last:___________________________ First: _________________	Subscriber SSN: – –	Patient's relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	

Birth date:	INS Effective Date	Group#:	Policy / Identification #:	Co-payment: $

Subscribers Address (if different from patients):

CONSENT TO TREATMENT/RELEASE INFORMATION: I grant Valley Medical Center Clinic Network Providers the authorization to administer medical treatment and perform medical procedures as deemed necessary. I authorize the release of medical information to my insurer, or the insurer's agents, to process my payments for service. To the best of my knowledge, all the information above is true and correct. I am aware that as a patient I have certain rights and responsibilities and I have been informed of and given access to Valley Medical Center's Notice of Privacy Practices, including access through their website at www.valleymed.org/privacy.

ASSIGNMENT OF BENEFITS: I hereby assign all benefits payable by my insurance company to the Valley Medical Center Clinic Network.

RECIPIENT OF ELECTRONIC MAIL CONSENT: I acknowledge that giving my email address authorizes the Clinic Network to send me Health Promotion and Patient Care Announcements.

FINANCIAL POLICY: I have been given and understand Valley Medical Center Clinic Network Financial Policy.

PATIENT/GUARDIAN SIGNATURE:	DATE:

I hereby authorize one or all of the designated parties listed below to request and verbally discuss any protected health information regarding my treatment, payment, or administrative operations related to treatment and payment, from any and all providers, billing agents or other appropriate employees of Valley Medical Center or any of its affiliated physicians or clinics. By affixing my signature below I hereby expressly waiver any and all claims against Valley Medical Center for any alleged inappropriate disclosures so long as Valley Medical Center is acting in good faith in its reliance on information provider by the apparent authorized designees.

The designee(s) will remain enforced until it is rescinded by the patient.

AUTHORIZED DESIGNEES:

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
PATIENT'S NAME:	**DATE:**	**PATIENT'S SIGNATURE:**

This request will remain in force until the patient discontinues the authorization.
The patient may change (add and/or delete designees), in person at the clinic at anytime. It is understood that the patient may be requested to show picture ID to change this request.

PATIENT SELF REPORT

Name of PCP: ____________________________ **Address:** ____ **Phone:** _______________
(Primary Care Provider)

Current medications: Please list the names of prescribed and non-prescribed drugs and over the counter herbs/replacements you are using.

Medication (Name, Dose, Frequency)	Clinician Comments

Previous Psychiatric Medications: Please list the names of prescribed and non-prescribed psychiatric drugs you have used in the past.

Name of Medication	Clinician Comments

Do you have any medication allergies? Please list:

____

Previous <u>MEDICAL</u> History	*Clinician Evaluation (for official use only)*
Illnesses: ____________________________	
Surgeries: ____________________________	
Describe your obstetrical history: ____________________	
Describe your method of contraception: ____________________	
Have you gained or lost weight in the last 6 months? ☐ Yes ☐ No If yes, explain: ____________________	

Previous PSYCHIATRIC History:	*Clinician Evaluation (for official use only)*
Have you ever been hospitalized? ☐ Yes ☐ No When? ____ Where? ____ Diagnosis? ____ Benefits? ____ Have you ever seen a Psychiatrist? ☐ Yes ☐ No For what condition? ____ ____ Have you ever seen a Counselor/Therapist? ☐ Yes ☐ No For what condition? ____ ____ ____ Have you ever made suicide attempt? ☐ Yes ☐ No If yes, details: ____ ____ ____ Violence (any self-injury, injury to others)? ☐ Yes ☐ No If yes, explain: ____ ____ Alcohol (quantity per day, is it or has it been a problem)? ☐ Yes ☐ No ____ ____ Drugs (present/past use, is it or has it been a problem)? ☐ Yes ☐ No ____ ____ Caffeine? ☐ Yes ☐ No If yes, describe: ____ ____ Nicotine use? ☐ Yes ☐ No If yes, describe (amount/frequency): ____	
Family/Social History:	*Clinician Evaluation (for official use only)*
Any mental illness in your family (including addictions)? ☐ Yes ☐ No If yes, describe: ____ ____ Family of Origin (where were you born and raised)? ____ How many siblings? ____ What was childhood like? ____ ____ ____ ____ Marital History? ____ ____ ____	

Family/Social History (cont):	*Clinician Evaluation (for official use only)*
Abuse: Sexual abuse? ☐ Yes ☐ No If yes, explain: ______ Physical abuse? ☐ Yes ☐ No If yes, explain: ______ Emotional abuse? ☐ Yes ☐ No If yes, explain: ______ **Current Social/Family System:** Child(ren)? ☐ Yes ☐ No Who are the supports in your life? ______ Who lives with you? ______ Are you working outside the house? ☐ Yes ☐ No If yes, where and doing what? ______ Education? ______ Any legal problems? ☐ Yes ☐ No If yes, explain: ______ Any financial problems? ☐ Yes ☐ No If yes, explain: ______ Any military service? ☐ Yes ☐ No Do you feel safe? (home, work, school)? ______ Sexual Orientation? ______ Religious beliefs/values? ______ What do you do in your spare time? ______ Last physical examination? ______ What are your goals for treatment? ______	