CALIFORNIA INTEGRATIVE HEALTHCARE/VALLEY NATURAL HEALTH REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Last Name: First: Middle:			Marital Status(circle one) Single / Married / Divorced / Separated / Widowed		
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:		Social Security no.:		Phone Number: ( )	
P.O. box/Apt	City:	State:	ZIP Code:		
Email:					
How did you hear about us: ❑ Dr. _____ ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Groupon ❑ Other_____					
Other Family Members seen here:					

INSURANCE- PLEASE GIVE INSURNACE CARD TO RECEPTIONIST

Responsible person:	Date of Birth:	Phone number:	
Occupation:	Employer:	Employer Address:	Employer Phone number: ( )
Primary Insurance Carrier	Group Number:	Policy number:	
Subscribers Name:	Subscribers SSN:	Subscribers DOB:	Member ID number:
Relationship to Subscriber if other than self:			
Secondary Insurance (if applicable):	Group Number:	Policy number:	
Relationship to Subscriber if other than self:			

IN CASE OF EMERGENCY

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

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize California Integrative Healthcare/Valley Natural Health to release any information required to collect owed debt.

Patient/Guardian signature *Relationship(if other than patient)* *Date*