



Valley Family Medicine
1505 Mill St
New London WI 54961
920-982-7900

Date _____

Home Phone _____

Cell Phone _____

Patient Information

Last Name _____ First _____ MI _____ Maiden name _____ SS# _____

Address _____ Drivers lic. # _____

Gender M F Age _____ Birth date _____ Marital Status _____ Religion _____

City _____ State _____ Zip _____ License Plate # _____

Do you own your home or rent? _____ if renting, name of landlord _____

How long at this address? _____ Prior address (if less than 2 years) _____

Bank Information _____ Checking or Savings? City _____

Patient Employed by _____ Occupation _____

Business Address _____ City _____ Bus Phone _____

In case of emergency who should we contact? _____

Emergency Contact (Person not residing with patient) _____

Whom may we thank for referring you to this practice? _____

Is patient employed anywhere other than above listing? _____

If so, other employers name, address and phone number. _____

Spouse Information

Last Name _____ First _____ MI _____ SS# _____

Address (if different) _____ Drivers Lic # _____

City _____ State _____ Zip _____ Home Phone _____ Cell _____

Employer _____ Address _____ Phone _____

Primary Insurance

Insured Name _____ Relationship to Patient _____ DOB _____

Insurance Company name _____ Subscriber # _____

Policy Number _____ Effective date _____ Employer Name _____

Secondary Insurance

Subscriber Name _____ SS# _____ DOB _____

Relationship to Patient _____ Address _____

Insurance Company name _____ Subscriber # _____ Policy # _____

Employer Name _____ Address/Phone _____

Additional Insurance

Is patient covered by additional insurance? Y N (Please provide copy of card)



Subscriber Name _____ SS# _____ DOB _____

Relationship to Patient _____ Address _____

Insurance Company name _____ Subscriber # _____ Policy # _____

Employer Name _____ Address/Phone _____

Assignment and Release

I, the undersigned certify that I (or my dependant) have insurance coverage with _____

_____ (Name of Insurance Co.) and assign directly to Dr. VanHoozen all insurance

benefits if any, otherwise payable to me for services rendered. I understand that I am financially

responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release

all information necessary to secure the payment of benefits. I authorize the use of this signature on

all insurance submissions.

Signature Relationship Date