

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

Date _____ Home Phone _____
Cell Phone _____

Patient Information

Name _____ SS # _____
Last Name First Name Initial (Maiden name)

Address _____ Drivers Lic. # _____

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 yrs) _____

City _____ State _____ Zip Code _____

Bank information _____ Checking or Savings?

City _____ State _____ Zip Code _____

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

Patient Employed by _____ Occupation _____

Business Address _____ City/St/Zip _____

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

Name _____ SS # _____
Last First Initial

Address (if different than patient) _____ Drivers Lic # _____

City _____ State _____ Zip Code _____ Home Phone _____

Employer _____ Employer Address _____

City _____ St _____ Zip _____ Telephone # _____

Primary Insurance

Primary insured name _____
Last First Initial
Relationship to Patient _____ Birth date _____ SS # _____
Address (if different) _____ City/St/Zip _____ Phone _____
Employer _____ Address _____ Phone _____
Insurance Co. _____ Subscriber # _____ Group # _____

Additional Insurance

Is patient covered by additional insurance? Y N Subscriber Name _____
Relationship to Patient _____ Birth date _____ SS # _____
Address _____ City/St/Zip _____ Phone _____
Employer _____ Address _____ Phone _____
Insurance Co. _____ Subscriber # _____ Group # _____

Assignment and Release

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