

**Integrated Medical Services (IMS)
New Patient Registration Sheet
VALLEY ORTHOPEDICS**



Personal Information

Today's Date: _____

Patient First Name: _____ Initial: _____ Last Name: _____

DOB: _____ Age: _____ Social Security #: _____ Email: _____

Address: _____
Street Apt # City/State/Zip

Home Phone: _____ Work Phone: _____ Cell phone: _____

Gender : M F Language: ENG SPAN OTHER: _____ Marital Status: S M W D O

Race/Ethnicity: ___ White ___ Black/African American ___ American Indian ___ Alaska Native ___ Asian
___ Native Hawaiian/Pacific Islander ___ Hispanic/Latino ___ Other _____

Occupation: _____ Retired: ___ YES ___ NO From: _____

Employer Name: _____ Phone Number: _____

Address: _____ City/State/Zip: _____

Primary Care Physician: _____ Referring Physician: _____

Financial Responsible Party Information

Responsible Party Name: _____ **Relationship to patient:** _____

DOB: _____ Age: _____ Social Security #: _____

Emergency Contact Name/ DOB: _____ **Phone Number:** _____

Relationship to patient: _____

Insurance Information

Primary Insurance: _____ **Address:** _____

Policy #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____ Relationship to patient: _____

Secondary Insurance: _____ **Address:** _____

Policy #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____ Relationship to patient: _____

**Integrated Medical Services (IMS)
New Patient Registration Sheet
VALLEY ORTHOPEDICS**



Reason for Visit

Primary reason for visit: _____ Date symptoms started: _____

Related to an Auto Accident? YES NO Work Related? YES NO Date of Injury: _____

Were you seen at the Hospital/Urgent Care: YES NO If YES, where? _____

Preferred Pharmacy Information

Pharmacy Name: _____ Phone #: _____ Fax #: _____

Address: _____ City/State/Zip: _____

Release of Information

The person listed below has my consent to receive medical information, concerning the above patient, in person or over the phone. They will also be able to pick up any necessary prescriptions (other than controlled substances), x-rays and lab slips.

Name: _____ Relationship to patient: _____ Phone Number: _____

AUTHORIZATION TO BILL/PAY: I HEREBY AUTHORIZE IMS AND ITS AFFILIATES TO RELEASE ANY INFORMATION REQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT WHICH COULD INCLUDE HIV, COMMUNICABLE DISEASE, OR DRUG ABUSE INFORMATION. I ALSO HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BUSINESS OFFICE OF IMS AND ITS AFFILIATES FOR THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. *I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE. FURTHER, I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES INCURRED IN THE COLLECTION OF MY ACCOUNT(S) AND WILL PAY ALL FEES INVOLVED SHOULD MY ACCOUNT(S) BE PLACED WITH A COLLECTION SERVICES.*

Patient/Guardian Signature

Printed Name

Date