HOLVIK FAMILY HEALTH CENTER

221 E. Caldwell Ave. VISALIA, CA 93277

PATIENT REGISTRATION FORM

Patient Name:	Date:
Address:	Account#
City, State, Zip:	Phone#:

Sex:	DOB:
Marital Status:	Cell Phone:
Employer:	Work Phone:
Student Yes: ☐ No: ☐	Ca. Drivers License\ID #:
Emergency Contact:	

PRIMARY INS:

Insured Employee's Name:	
Date of Birth:	
Identification\Subscriber #:	
Group #:	
Co-Payment Amount:	

SECONDARY INS:

Insured Employee's Name:	
Date of Birth:	
Identification\Subscriber #:	
Group #:	
Co-Payment Amount:	

As a courtesy, our office will bill your insurance for you. You are responsible for the deductible, share of cost, co-payment at time of visit, and any costs that are not a benefit of your plan. If you do not have insurance we would appreciate payment at the time of your visit. Our staff is available if you have questions or need to make payment arrangements.

I authorize payment of medical benefits to be paid directly to the physician provider for services rendered.
I authorize my doctor to release any medical or other information necessary to precess claims with my insurance companies.
I request payment of any government benefits to the party who accept assignment. I authorize use of information from this form to bill my insurance companies.

Patient's Signature: Date: