MidValley Healthcare

Behavioral Health and Addiction Recovery

Patient Information

Please Print Clearly

use black or blue ink

Please DOWNLOAD and complete forms in Acrobat (not in the web browser), save, email to Admin@midvalleyhealthcare.com , RoxanneH@midvalleyhealthcare.com , and gillies.katie@midvalleyhealthcare.com.

Note: By printing your name on the signature line, you consent to treatment.

Patient Name: _____ DOB: _____

Preferred Name:_____ **Sex:** ◉M ○F **Social Security Number:**_____-_____-

Marital Status: ◉Single ○Married ○Divorced ○Widowed ○Separated

Tobacco use: ◉Daily ○Sometimes ○Former ○Never

Preferred Language: ☐English ☐Spanish ☐Other: _____.

Address:_____ **Apt #:**

City:_____ **State:**_____ **Zip:**

Cell Phn #:_____ **Work Phn #:**_____ **Home Phn #:**

Email Address:

I would like appointment reminders via: (check all that apply) ☐Text message ☐Email ☐Voice message ☐I decline

I would like my telemed appointment link sent via (check only one) ☐ Text message ☐ Email **(Please sign Telemed consent form)**

Employment Status: ○Full time ○Part time ○Retired ○unemployed ○Student

Name of employer: _____.

Insurance Information Present your Insurance card to the front desk --A COPY MUST BE ON FILE

Please note, that if you do not have your insurance card, you are responsible for your bill in full.

Primary Insurance Company name and address:_____ _____

Subscriber Name: _____Date of Birth: _____SSN:

Relationship to Patient: _____Policy #: _____Group #:

Secondary Insurance Company name and address:_____

Subscriber Name: _____Date of Birth: _____SSN:

Relationship to Patient: _____Policy #: _____Group #:

Is this Work Related? ◉Y ○N W/C Carrier name & phone:

Guarantor's Information (responsible party for billing)

Relationship to patient: ☐Self ☐Spouse ☐Parent ☐Other: _____

Guarantor's Name: _____ Phn#:

Guarantor's Social Security Number:_____-_____-_____ Date of Birth:

Address (If Different):_____City:_____State:_____Zip:

Name of employer/address:_____Business Phone:

_____

Pharmacy name:_____ **City:**_____**State:**_____

Zip code:_____ **Cross Roads:**_____

Emergency Contact Information

Name of nearest relative not residing with patient:_____

Relationship:_____ Home Phn #: _____Work Phn #: a

How Did You Hear About Our Office:

☐Web site ☐Friend or Family Member ☐Referral from another provider:

(Provider Name and Phone Number)

_____

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By signing below, I hereby consent to the treatment to be provided by MidValley Healthcare. I understand that treatment will be discussed prior to being rendered.
(Consent must be given in order to be seen today)

Patient Signature:_____**DATE:**_____