

# Welcome



*Thank You For Choosing Valir As Your Health Care Provider!*

Patient Name: _____	Home Phone: _____
Address: _____	Work Phone: _____
City/State/Zip: _____	Cell Phone: _____
Date of Birth: _____	Email: _____
Social Security: _____	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male
Drivers License Number: _____ State: _____	Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> O
Employer: _____	Spouse: _____
Address: _____	Spouse Phone: _____
City/State/Zip: _____	
Emergency Contact: _____ Relation: _____	Phone: _____

*If the patient is a minor, please complete the following information regarding the Guarantor (person responsible for payment):*

Name: _____	Phone: _____
Address: _____	Date of Birth: _____
City/State/Zip: _____	Social Security: _____
Employer: _____	Employer Phone: _____
Address: _____	Employer Fax: _____
City/State/Zip: _____	

Were you involved in an accident?  Y  N Injury Date: \_\_\_\_\_  
Is your injury work related or did it occur on the job?  Y  N Injury Date: \_\_\_\_\_

Attorney: _____	Phone: _____
Firm: _____	Fax: _____
Address: _____	
City/State/Zip: _____	

1st Insurance: _____	Phone: _____
Policy Holder Name: _____	Employer: _____
Date of Birth: _____	Social Security: _____
Group #: _____	Policy/Claim #: _____
Adjuster: _____	Adjuster Phone: _____

2nd Insurance: _____	Phone: _____
Policy Holder Name: _____	Employer: _____
Date of Birth: _____	Social Security: _____
Group #: _____	Policy/Claim #: _____

*I understand and agree that health and accident insurance policies are a contract between an insurance carrier and the policy holder/insured. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that any amounts that are patient due are due on the date of service. I also certify that the above information is true and correct to the best of my knowledge. I understand that missing a scheduled appointment without providing 24 hours notice to this office will result in a \$20.00 charge that will be due at the next appointment.*

Patient's/Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_