VIVA! WELLNESS
PATIENT REGISTRATION FORM

PATIENT INFORMATION ** (Name must match insurance card) **

PATIENT NAME _____ **Nickname** _____
(Last) (First) (MI)

FORMER LAST NAME (if applicable) _____ **SS#** _____-_____-_____ **DATE OF BIRTH** _____

ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP** _____

PREFERRED PHONE (_____)_____-_____ **MAY WE LEAVE A DETAILED MESSAGE?** ☐ Yes ☐ No

SECONDARY PHONE (_____)_____-_____ **MAY WE LEAVE A DETAILED MESSAGE?** ☐ Yes ☐ No

MARITAL STATUS (circle one): SINGLE MARRIED DIVORCED WIDOWED

RACE (circle one): WHITE BLACK/AFRICAN AMERICAN ASIAN AMERICAN INDIAN/ALASKA NATIVE HISPANIC OTHER DECLINED

EMPLOYER _____ **WORK #** (_____) _____-_____ **OCCUPATION** _____

EMERGENCY CONTACT PERSON _____ **PH #** (_____) _____-_____ **RELATION** _____

HOW DID YOU HEAR ABOUT US? ☐ INTERNET ☐ PHONEBOOK ☐ PRINT AD ☐ RADIO ☐ OTHER _____

EMAIL ADDRESS _____

INSURANCE INFORMATION *(must be completed even though insurance card is provided)*

PRIMARY INSURANCE COMPANY _____ **SUBSCRIBER'S NAME** _____

RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER **SUBSCRIBER BIRTH DATE** _____/_____/_____

SUBSCRIBER SS # _____-_____-_____ **ID # ON CARD** _____ **GROUP #** _____

SECONDARY INSURANCE COMPANY _____ **SUBSCRIBER'S NAME** _____

RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER **SUBSCRIBER BIRTH DATE** _____/_____/_____

SUBSCRIBER SS # _____-_____-_____ **ID # ON CARD** _____ **GROUP #** _____

RESPONSIBLE FINANCIAL PARTY (IF DIFFERENT FROM PATIENT)

NAME _____ **DATE OF BIRTH** _____ **RELATIONSHIP TO PATIENT** _____

MAILING ADDRESS _____
(Street or PO Box) (City) (State) (Zip)

DRIVER'S LICENSE # _____ **SS #** _____-_____-_____ **PHONE #** (_____) _____-_____
☐ HOME ☐ CELL ☐ WORK

The above information is true to the best of my knowledge. I authorize payment of medical benefits to VIVA! WELLNESS. I understand that regardless of insurance coverage, I am financially responsible for all charges. If my account is assigned to a collection agency I will be responsible for all charges associated with collection. Most labs collected in this office will need to be sent to an outside lab for testing and those charges are separate from the charges incurred in this office. I have been offered a copy of VIVA! WELLNESS' Notice of Privacy Practices and agree to HIPAA required use and disclosure of my protected health information for payment, treatment, and health care operation. I understand and agree the no-shows and cancellations without a 24 hour notice may be charged a $25.00 fee. All returned checks will be charged a $35.00 fee.

_____ _____ _____
Patient or Responsible Party Signature **Print Responsible Party's Name** **Date**