MidValley Healthcare

Behavioral Health and Addiction Recovery

Patient Information

Please Print Clearly

use black or blue ink

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)

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:** _____