TriValley Primary Care

Patient Registration Form

Please print the information requested in the spaces provided. Thank you.

PATIENT INFORMATION	**PHOTO ID REQUIRED**	**Todays Date:**	
LAST NAME		PRIMARY CARE PHYSICIAN	
FIRST NAME	M.I.	DATE OF BIRTH	
PREVIOUS NAME		SEX ☐ Male ☐ Female	
ADDRESS		MARITAL STATUS ☐ S ☐ M ☐ D ☐ W	
CITY		SOCIAL SECURITY NUMBER	
STATE	ZIP	EMPLOYER	
HOME PHONE	CELL PHONE	EMPLOYER ADDRESS	
WORK PHONE	PREFERRED CONTACT PHONE ☐ Home ☐ Cell ☐ Work	EMPLOYER CITY	STATE / ZIP
TVPC HAS PERMISSION TO SEND TEXT MESSAGE REMINDERS AND NOTIFICATIONS TO MY CELL PHONE ☐ YES ☐ NO		EMPLOYMENT STATUS	STUDENT STATUS

RESPONSIBLE PARTY ☐ **Check here if self**		**EMERGENCY CONTACT**	
LAST NAME		LAST NAME	
FIRST NAME / M.I.		FIRST NAME / M.I.	
ADDRESS		ADDRESS	
CITY		CITY	
STATE / ZIP		STATE / ZIP	
HOME PHONE	CELL PHONE	HOME PHONE	CELL PHONE
WORK PHONE	EXT	WORK PHONE	EXT
DOB	SEX ☐ Male ☐ Female	DOB	SEX ☐ Male ☐ Female
RELATIONSHIP		RELATIONSHIP	

PRIMARY & SECONDARY INSURANCE (PRESENT INSURANCE CARDS TO FRONT DESK)

PRIVACY NOTICE: I acknowledge that I have been provided TriValley Primary Care's Notice of Privacy Practices **initial here**

I authorize TriValley Primary care to leave protected health information on an answering machine/voicemail at the following number/s:_____(void if blank)

The following is my personal representative for health matters. Important: Information passed on to the personal representative is equivalent to communicating with the patient.

Name:	Relationship:	Telephone Number:
_____	_____	_____
_____	_____	_____

Patients may request alternate means to communicate with them or an alternate location. If TriValley incurs an expense to effect the alternate means/location, it must be borne by the patient, or it shall not be approved. Please list alternative means of communication on the back of this form.

Signature of Patient (or POA)_____ Date _____

STATISTICAL DATA: SOLICITED PER FEDERAL MEANINGFUL USE REGULATIONS (ARRA - 2009)

EMAIL	RACE
ETHNICITY	LANGUAGE