VALLEY HEALTH TEAM
LIVE BETTER. VIVE MEJOR.

PATIENT INFORMATION

Name: _____Social Security Number: _____
Last *First* *Middle*
Street Address: _____City: _____State: _____ Zip Code: _____

Date of Birth: _____ Phone Number: _____ Email address: _____

Last Name at Birth: _____ Female _____ Male_____ Primary Language: English/Spanish/Punjabi/Hindi/Other: _____

Do we need to contact you at a different mailing address, phone number or through an alternate method for confidential issues? ___ Yes___ No

Mailing Address (*If different from above):*

Address: _____City: _____ State: _____Zip Code: _____

Other Name(s) Used: _____

Marital Status: Single/Married/Divorced/Widowed/Legally Separated/Partner/Unknown *(Please circle one)*

If the client is a child are they in Foster Care? ___ Yes ___No

EMERGENCY CONTACT

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Alternate Phone: _____

Relationship to Client: _____ Client's Legal Guardian? ___Yes ___No

EMPLOYER INFORMATION

Employment Status: Employed Full Time / Employed Part Time/ Self Employed/ Retired/ Military/ Student Full Time / Student Part Time / Unemployed/ Unknown
(Please circle one)
Employer Company Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Occupation: _____

GUARANTOR (Person responsible for payment)

Name: _____ Last Name at Birth: _____
Last *First* *Middle*
Billing Address: _____ Date of Birth _____ Phone Number: _____
(Month/day/year)
City: _____ State: _____ Zip Code: _____ Relationship to Patient: _____

Social Security Number: _____ Who is your primary care provider? _____

INSURANCE INFORMATION

Name of Primary Insurance Company: _____

Name of Policy Holder: _____ Relationship to Patient: _____
Last *First* *Middle*
Policy Holder Address: _____Phone: _____Policyholder SSN: _____

Insurance ID: _____ Group#:_____ Policyholder Date of Birth: _____