



Patient Registration Form

Date:

Patient Information

Last Name: First Name: Middle Name:

Preferred Name:

Date of Birth (DOB): Social Security Number (SSN):

Country of Birth:

Mailing Address

Street:

Apt #:

City:

State:

Zip:

Home Address (If Different from Mailing)

Street:

Apt #:

City:

State:

Zip:

Email Address: (for patient portal *must be 18 years of age or older)

Home Phone: Ok to leave voice message: ☐ Yes ☐ No

Cell Phone: Ok to leave voice or text message: ☐ Yes ☐ No

Work Phone:

Primary Contact: ☐ Home ☐ Cell ☐ Work
☐ Opt out of all Practice Communication

Best time to reach you: ☐ AM ☐ PM

Preferred Language: Interpreter Needed?: ☐ Yes ☐ No

Emergency Contact

Full Name: Relationship:

Address:

Phone Number:

Additional Information Requested

Race – Check as many as apply: ☐ White ☐ Black/African American ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian: ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Guamanian or Chamorro ☐ Samoan ☐ American Indian ☐ Alaskan Native ☐ North African or Middle Eastern ☐ Other: ☐ Unreported/Refused	
Ethnicity – Check one: ☐ Hispanic ☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ Non-Hispanic ☐ Unreported/Refused ☐ Other:	
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Partner	
Housing Status: ☐ Own – Private ☐ Rent – Private ☐ Senior Housing ☐ Homeless Shelter ☐ Street ☐ Transitional ☐ Doubling up ☐ Section 8/Housing Program ☐ Public Housing	
Student: ☐ Full Time ☐ Part Time ☐ Not a Student	
Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Active Military ☐ Reserved Military ☐ Self Employed ☐ Not Employed	
Employer Name:	
Veteran: ☐ Yes ☐ No Board Member: ☐ Yes ☐ No VIP Employee: ☐ Yes ☐ No	
How did you hear about us? ☐ Friend/Relative/Word of Mouth ☐ VIP Employee ☐ VIP Community Events ☐ VIP Community Partnerships ☐ Facebook/Social Media ☐ Website ☐ Print Media/TV/Radio ☐ Insurance Company ☐ Other:	
Parent/Legal Guardian Information (if patient is under 18 years of age)	
Mother's Name:	Father's Name:
DOB:	DOB:
Phone:	Phone:
Address:	Address:
Legal Guardian's Name (if different from Parent):	
DOB:	
Phone:	
Address:	
Primary Care Provider	
PCP Name:	
Phone:	
Address:	

Advanced Directives	
Advanced Directive: ☐ Yes ☐ No ☐ Decline	Living Will: ☐ Yes ☐ No
Other Healthcare Providers	
1. Provider Name:	Phone:
Specialty:	Fax:
2. Provider Name:	Phone:
Specialty:	Fax:
3. Provider Name:	Phone:
Specialty:	
Fax:	

Financial Responsibility Agreement

We accept most insurance plans; however, you are responsible for verifying that we are a participating member with your insurance. If you do not have insurance, we are still committed to serving you. We offer a sliding fee scale (based on income) for payment. We also have dedicated staff members available to help patients enroll in insurance plans.

Assignment of Benefits:

I assign to VIP's all benefits to which I may be entitled from Medicare, Medicaid, other government agencies, insurance carriers and other third parties who are financially liable for the medical care and treatment provided by VIP Community Services.

Financial Obligation:

I agree, that, except as may be limited by law or VIP's agreements with third party payers, in the event of non-payment by a third party for which I have provided an assignment of benefits, I am obligated to pay all amounts due for services provided at VIP Community Services facilities in accordance with the rates and terms of VIP in effect on the date of service. I also agree that I am responsible for any applicable copayments, coinsurance, or deductibles.

Insurance Information

Primary Insurance Name:	
Policy #:	
Name of the Insured:	
DOB of Insurance Holder:	
Patient's Relationship to the Insured:	☐ Self ☐ Spouse ☐ Child ☐ Other:
Primary Care Provider on Insurance Card:	
Secondary Insurance Name:	
Policy #:	

I hereby authorize VIP Community Services to furnish medical information to my insurance carrier in accordance with their privacy policy.

By signing this acknowledgement, you (or the guarantor for the patient) accept full responsibility for payment of the services and supplies rendered by VIP Community Services.

Print Name of Patient or Responsible Party:

Date:

Signature of Patient or Responsible Party:

Date:

Pharmacy Information

Pharmacy Name:	
Phone:	
Address:	