Internal Medicine
Associates of the Grand Valley
Community HOSPITAL

607 28 1/4 Road
Grand Junction, CO 81506
Phone (970) 243-3300
Fax (970) 243-4464

# Pre-Registration Form

| ***Patient Information*** | | | | |
|---|---|---|---|---|
| Last Name* | First Name* | MI* | | Home Phone* |
| Address* | Mailing Address (if different)* | | | Work Phone* |
| City* | State* | Zip* | M F<br>Sex | Cell Phone* |
| Employer/School (if student) | | Social Security Number* | Y N<br>Employed | Date of Birth* |
| Employer Address | | Occupation | | Marital Status*<br>S M W D |
| Preferred Name | E-mail Address* | | | Doctor* |

| ***Preferred Communications*** | | | |
|---|---|---|---|
| Email | Fax | Mail | Text |
| Other | Phone | Patient Portal | Unknown |

| ***In Case of Emergency*** | | | |
|---|---|---|---|
| Emergency Contact Name* | Address | Date of Birth Phone* | Relationship* |

| Insurance Information | | | | |
|---|---|---|---|---|
| Insurance Company Name | Address | City | State | Zip |
| Group Name or Number | Insurance ID Number | Phone | | |

***All fields/sections marked with an * must be completed.***

Please turn over to complete page 2

# Pre-Registration Form

| | | | | |
|---|---|---|---|---|
| Name of the Insured Party (if not the patient)* | | | | Insured Date of Birth* |
| Insured Party Employer | | Employer Plan<br>Y N | | Relationship* |
| **Secondary Insurance Information** | | | | |
| Insurance Company Name | Address | City | State | Zip |
| Group Name or Number | Insurance ID Number | Phone | | |
| Name of the Insured Party (if not the patient) | | Insured Date of Birth | | |
| Insured Party Employer | | Employer Plan<br>Y N | | Relationship |
| If Workman's Comp Claim- Name, Address and Phone Number of Employer at time of injury | | | | |

| ***Race (circle one)*** | | ***Language (circle one)*** | |
|---|---|---|---|
| American Indian/<br>Alaska Native | Asian | Declined | English |
| Black/<br>African American | Declined | French | German |
| Native Hawaiian/ Pacific Islander | Other Race | Italian | Japanese |
| Unknown | White | NA | Other |
| ***Ethnicity (circle one)*** | | | |
| Declined | Hispanic or Latino | Asian | Spanish |
| Not Hispanic or Latino | Unknown | Chinese | Unknown |

| **Payment for Service** | | **Medical Release Authorization** | |
|---|---|---|---|
| I agree to pay all fees and charge at the time of treatment unless satisfactory credit or Insurance agreement have been made in advance. I agree to pay all attorneys' fees and costs to the above doctors for any charges incurred to collect any unpaid balance. All past due balance over 30 days will be charged 1.5% interest per month not to exceed 18% annually. | | I request that payment of authorized Medicare benefits or other Insurance benefits be made either to me or on my behalf directly to Internal Medicine Associates of the Grand Valley for any service furnished to me by these physicians. I Authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent of my insurer any information needed to determine the benefits payable for related services. | |
| Patient's or Authorized Person's Signature* | Date:<br>/ / | Patient's or Authorized Person's Signature* | Date:<br>/ / |

***All fields/sections marked with an * must be completed.***