

Internal Medicine

Associates of the Grand Valley



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Grand Junction, CO 81506
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Pre-Registration Form

Patient Information					
Last Name*	First Name*	MI*	Home Phone*		
Address*	Mailing Address (if different)*			Work Phone*	
City*	State*	Zip*	M F Sex	Cell Phone*	
Employer/School (if student)		Social Security Number*		Y N Employed	Date of Birth*
Employer Address		Occupation		Marital Status* 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.*

Pre-Registration Form

Name of the Insured Party (if not the patient)*				Insured Date of Birth*	
Insured Party Employer		Employer Plan 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 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/ Alaska Native	Asian		Declined	English	
Black/ 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		
<p>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.</p>			<p>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.</p>		
Patient's or Authorized Person's Signature*		Date: / /	Patient's or Authorized Person's Signature*		Date: / /

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