

Andrew S. Cook M.D.
Linda Mavity N.P.
Kirsten Conrad, N.P.
Lene Joy, RNP/Health Coach



15055 Los Gatos Blvd., Suite 250
Los Gatos, CA 95032
Tel (408) 358-2511
Fax (408) 358-1009
www.VitalHealth.com

Patient Registration Form

How did you hear about Dr. Cook? _____

Date: _____

IN OUT

PERSONAL INFORMATION:

Name: _____	Preferred Name in our office: _____
Address: _____	City: _____ State: _____ Zip: _____
SSN: _____	Birth Date: _____ Age: _____

CONTACT INFORMATION:

Home Tel: _____ <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Msg ok?	Work Tel: _____ <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Msg ok?	Cell Tel: _____ <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Msg ok?
Fax: _____	Email: _____ <input type="checkbox"/> I want to receive email updates from VHI <input type="checkbox"/> I do not want to receive email updates from VHI	
Mailing Address: _____ <small>(If different than residence address)</small>		
EMERGENCY CONTACT Name: _____ Relationship: _____ Tel: _____		

EMPLOYMENT INFORMATION:

Occupation: _____	Employer: _____	# of years: _____
Employer's Address: _____		City: _____ State: _____ Zip: _____

SPOUSE/SIGNIFICANT OTHER INFORMATION:

Spouse/Significant Other: _____	Work Tel: _____	Cell Tel: _____
Occupation: _____ Employer: _____		

INSURANCE INFORMATION: I certify that I, and/or my dependents(s) have insurance coverage with:

Primary		
Insurance Carrier: _____	<input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> HSA <input type="checkbox"/> HMO <input type="checkbox"/> Other: _____	
Name of Insured: _____	SSN of Insured: _____	
ID#: _____	Group#: _____	Insurance Tel: _____
Secondary		
Insurance Carrier: _____	<input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> HSA <input type="checkbox"/> HMO <input type="checkbox"/> Other: _____	
Name of Insured: _____	SSN of Insured: _____	
ID#: _____	Group#: _____	Insurance Tel: _____

I assign directly to Dr. Andrew Cook all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Cook may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. **I confirm that I do not have Medi-Cal or Medicaid coverage.** _____ (Signature)

WHO IS RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT? If not patient, they will need to complete additional form.

Name: _____	Relationship: _____	Home Tel: _____
Address: _____		City: _____ State: _____ Zip: _____