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PATIENT REGISTRATION FORM – DR. COOK, MD

How did you hear about Vital Health Institute?________________________________ Date: ______________
☐ IN ☐ OUT _______

Name:______________________________ Preferred Name in the Office: ______________
Address:____________________ City: ______________ State: _____ Zip:____________
SSN:____________________ Birth Date:________________ Age: ____________

Mobile #:____________________ ☐Primary ☐ Secondary ☐ Msg ok?
Home #:____________________ ☐Primary ☐ Secondary ☐ Msg ok?
Work #:____________________ ☐Primary ☐ Secondary ☐ Msg ok?

Fax ____________________ Email:______________________________
SKYPE or FaceTime ID: Preferred appointment reminder method? ☐ Telephone ☐ Email

Mailing Address:____
(If different than residence address)

Emergency Contact:____________________ Relationship:____________ Tel #:____________

EMPLOYMENT INFORMATION:
Occupation____________________ Employer:____________________ # of years:________

SPOUSE / SIGNIFICANT OTHER INFORMATION:
Name: ________________ Work#:________________ Mobile #:________________
Occupation____________________ Employer:______________________________

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

Insurance Carrier: ____________________ ☐ PPO ☐ POS ☐ HSA ☐ HMO ☐ Other:____________
Is this an Obama Heath Care Plan? NO, if YES, Circle Tier Level: Bronze Silver Gold Platinum

Name of Primary Subscriber on the Plan:________________ Relationship to Patient____________
Date of Birth & SSN of Primary: ________________ Insurance Tel#:____________
ID# ____________________ Group# ____________________
Claims Address: ____________________________ Co-Pay$: ____________
____

Who is financially responsible for all charges whether or not paid by insurance: _________________________________
Contact Information: Tel: _________________________ Relationship to Patient: ____________________________

I authorize the use of my signature on all insurance submissions. I assign directly to Vital Health Institute ("VHI") all insurance benefits, if any, otherwise payable to me for services rendered. VHI may use my heath care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I understand that VHI will submit claims to my Primary Insurance Carrier only; I will be responsible for submitting to a Secondary Insurance Carrier, if applicable. ______________ Initial

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