Welcome

Thank You For Choosing Valir As Your Health Care Provider!

Patient Name: _____ **Home Phone:** _____
Address: _____ **Work Phone:** _____
City/State/Zip: _____ **Cell Phone:** _____
Date of Birth: _____ **Email:** _____
Social Security: _____ **Gender:** Female Male
Drivers License Number: _____ **State:** _____ **Marital Status:** S M W D O
Employer: _____ **Spouse:** _____
Address: _____ **Spouse Phone:** _____
City/State/Zip: _____
Emergency Contact: _____ **Relation:** _____ **Phone:** _____

If the patient is a minor, please complete the following information regarding the Guarantor (person responsible for payment):

Name: _____ **Phone:** _____
Address: _____ **Date of Birth:** _____
City/State/Zip: _____ **Social Security:** _____
Employer: _____ **Employer Phone:** _____
Address: _____ **Employer Fax:** _____
City/State/Zip: _____

Were you involved in an accident? ☐ Y ☐ N **Injury Date:** _____
Is your injury work related or did it occur on the job? ☐ Y ☐ N **Injury Date:** _____

Attorney: _____ **Phone:** _____
Firm: _____ **Fax:** _____
Address: _____
City/State/Zip: _____

1st Insurance: _____ **Phone:** _____
Policy Holder Name: _____ **Employer:** _____
Date of Birth: _____ **Social Security:** _____
Group #: _____ **Policy/Claim #:** _____
Adjuster: _____ **Adjuster Phone:** _____

2nd Insurance: _____ **Phone:** _____
Policy Holder Name: _____ **Employer:** _____
Date of Birth: _____ **Social Security:** _____
Group #: _____ **Policy/Claim #:** _____

I understand and agree that health and accident insurance policies are a contract between an insurance carrier and the policy holder/insured. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that any amounts that are patient due are due on the date of service. I also certify that the above information is true and correct to the best of my knowledge. I understand that missing a scheduled appointment without providing 24 hours notice to this office will result in a $20.00 charge that will be due at the next appointment .

Patient's/Parent's/Guardian's Signature *Date*