## MId-Valley Behaivoral Health and Psychological Services, PLLC

# REGISTRATION FORM

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| Fecha de Hoy: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PCP: | | | | | | | | | | | | | | | | | | | | | | |
| INFORMACION DE PACIENTE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nombre Completo: | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | ❑ Sr.  ❑ Sra. | | | |  | | | | Estado Civil (Marca uno) | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Soltero / Casado / Div / Sep / Budo | | | | | | | | | | | | | | | |
| Este es su nombre legal? | | | | | | Si no, que es su nombre legal?: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Fecha de Nacimiento: | | | | | | | | | | | | | Edad: | | | Sexo: | | | | |
| ❑ Yes | | ❑ No | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | / / | | | | | | | | | | | | |  | | | ❑ M | | | ❑ F | |
| Direccion fisico: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Numuro de seguro social.: | | | | | | | | | | | | | | | | Numero De Telefono.: | | | | | | | | | | | |
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| P.O. box: | | | | | | | | | | Cuidad: | | | | | | | | | | | | | | | | | | | | | | | | | | Estado: | | | | | | | | | | | | Codigo Postal: | | | | | | | | | |
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| Occupaccion: | | | | | | | | | | Donde Trabaja: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Telefono de Trabajo.: | | | | | | | | | | | | |
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| A quien le damos las gracias por recomendarle a nuestra oficina : | | | | | | | | | | | | | | | | | | | | | | | | | | | | ❑ Dr. | | |  | | | | | | | | | | | | | | | | ❑ Insurance Plan | | | | | | | | ❑ Hospital | | |
| ❑ Family | | | ❑ Friend | | | | ❑ Close to home/work | | | | | | | | | | | | | | | | | ❑ Yellow Pages | | | | | | | | | | | | ❑ Other | | | | | | |  | | | | | | | | | | | | | | |
| Otra familiar que recibe servicios con nosotros?: | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| INFORMACION DE SU SEGUROS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (Por favor, dar su tarjeta de seguro a la recepcionista) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Quien es responsable por la cuenta: | | | | | | | | Fecha de Nac: | | | | | | | | | | | | | Direccion (si es diferente): | | | | | | | | | | | | | | | | | | | | | | | | Num. De Telefono.: | | | | | | | | | | | | |
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| Este persona es paciente aqui? | | | | | | | | ❑ Si | | | | | | | | ❑ No | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| Ocupaccion: | | | | Donde Trabaja: | | | | | | | | | | | Direccion de Trabajo: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Num. De Tel De Trabajo.: | | | | | | | | | | | | |
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| Es incluydo esta persona en el seguro? | | | | | | | | | | | | ❑ Si | | | | | | | | ❑ No | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Marca el Seguro Primario | | | | | | | | | ❑ [Insurance] | | | | | | | | | | | | | | ❑ [Insurance] | | | | | | | | | ❑ [Insurance] | | | | | | | | | | | | ❑ [Insurance] | | | | | | | | ❑ [Insurance] | | | | | |
| ❑ [Insurance] | | | | | ❑ [Insurance] | | | | | | | | | | | | ❑ [Insurance] | | | | | | | | | ❑ Welfare (Please provide coupon) | | | | | | | | | | | | | | | | | | ❑ Other | | | | |  | | | | | | | | |
| Subscriber’s name: | | | | | | | | | Subscriber’s S.S. no.: | | | | | | | | | | | | | | | | Birth date: | | | | | | | | Group no.: | | | | | | | | | | | | Policy no.: | | | | | | | | | Co-payment: | | | |
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| Patient’s relationship to subscriber: | | | | | | | | | | | | | ❑ Self | | | | | | | | | ❑ Spouse | | | | | | ❑ Child | | | | | ❑ Other | | | | | | |  | | | | | | | | | | | | | | | | | |
| Name of secondary insurance (if applicable): | | | | | | | | | | | | | | | | | | | Subscriber’s name: | | | | | | | | | | | | | | | | | | | | | Group no.: | | | | | | | | | | | Policy no.: | | | | | | |
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| Patient’s relationship to subscriber: | | | | | | | | | | | | | | ❑ Self | | | | | | | | ❑ Spouse | | | | | | ❑ Child | | | | | ❑ Other | | | | | | |  | | | | | | | | | | | | | | | | | |
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| EN CASO DE EMERjencia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nombre de Amistad or Familiar (no viviendo con usted): | | | | | | | | | | | | | | | | | | | | | | | | | | | Relacion con el Paciente: | | | | | | | | | | | | Telefono.: | | | | | | | | | | | Celular.: | | | | | | | |
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| La información anterior es verdadera a lo mejor de mi conocimiento. Autorizo ​​a mis beneficios del seguro se pagará directamente al médico . Entiendo que soy financieramente responsable de cualquier balance . También autorizo ​​a Mid-Valley Behaivoral Servicios Psicológicos Salud y , PLLC o compañía de seguros para liberar toda la información necesaria para procesar mis reclamos . | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Patient/Guardian signature | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | Date | | | | | | | | | | | | | | | |  |