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Vital Health
ENDOMETRIOSIS CENTER

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PATIENT REGISTRATION FORM

How did you hear about Vital Health Institute?_____ Today's Date: _____

TIME ZONE: _____ ☐ IN ☐ OUT _____

Name:_____ Preferred Name in the Office: _____

Address:_____ City: _____ State: _____ Zip:_____

SSN:_____ Birth Date:_____ Age: _____

Mobile #:_____ Home #:_____ Work #:_____

☐Primary ☐ Secondary ☐ Msg ok? ☐Primary ☐ Secondary ☐ Msg ok? ☐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 Affordable Care Act Plan? 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: _____

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 health 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