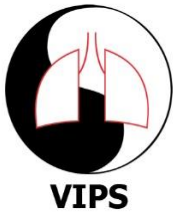


**VALLEY INTENSIVISTS, PULMONOLOGISTS AND SLEEP SPECIALISTS**

1200 E. Savannah Ave. Suite 12
McAllen, TX 78503
Tel: (956) 688-6300 Fax: (956) 688-6303

## Patient Registration

Please print clearly and provide all information so that your claim can be processed quickly and efficiently. Thank you.

Name: _____ Date of Birth: _____

SS #: _____ Age: _____ Sex: _____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell #: _____ Alternate Phone #: _____

Employer: _____ Work #: _____

Email: _____

Insurance Company: _____

Policy #: _____ Group #: _____

Referring Doctor: _____

**If you are insured under your spouse/ parent/ guardian, please provide us with primary insured's information.** ***If this does not apply to you, please provide us a responsible party's information of which we will only release records to.***

Name: _____ Date of Birth: _____

Address: _____

Cell #: _____ Alternate Phone #: _____

Employer: _____ Work #: _____

Relationship to Patient: _____

_____ _____
Patient Signature Date

_____ _____
Pharmacy Information Phone Number