Platte Valley Clinic
Saratoga, WY

1208 River Street, Saratoga, WY 82331
Ph: 307-326-3169 : Fax: 307-326-3259
plattevalleyclinic@hmsmt.com : plattevalleyclinic.com

Please review and update the information below to the best of your ability

Patient Registration

Current Patient Information – Please Print
Last Name:
First Name:
Middle Name:
Address:
City, State, Zip:
Home Phone:
Work Phone:
Mobile Phone:
Sex:
Date of Birth:
Social Security No.:
Patient email:
Required by government mandate
(although you may refuse to answer)
Language:
Race:
Ethnicity:
Marital Status:

Guarantor Information (to whom statements are sent)

Name:
Address:
City, State, Zip:
Relationship to patient:
Date of Birth:
Social Security No.:
Phone:

Emergency Contact Information

Name:
Relationship:
Phone:
Cell:

Employer Information

Employer:
Address:
Phone:

Other

Patient referred by:
Primary Care Provider:
Contact Preference: Home Cell
Work Patient Portal Email

Pharmacy Information

Name: Crossroads/Address:
Crossroads/Address: Phone:
Phone:
Insurance Plan Name:

Primary Insurance Information

Insurance Plan Name:
Last Name:
First Name:
Middle Name:
Address:
City, State, Zip:
Date of Birth: Sex: M F
Patients relationship to policy holder:
Employer Name:

Secondary Insurance Information

Insurance Plan Name: First Name:
Last Name:
First Name:
Middle Name:
Address:
City, State, Zip:
Date of Birth: Sex: M F
Patients relationship to policy holder:
Employer Name:

To the best of my knowledge the above information is complete and accurate.

_____ _____

Signature Date

Platte Valley Clinic
Saratoga, WY

1208 River Street, Saratoga, WY 82331
Ph: 307-326-3169 : Fax: 307-326-3259
plattevalleyclinic@hmsmt.com : plattevalleyclinic.com

Please sign and date each item below

ACKNOWLEDGEMENT AND AUTHORIZATION

I have read and understand the HIPAA/Privacy policy for Platte Valley Clinic.

Signed: _____ Date: _____

I hereby assign my insurance benefits to be paid directly to the healthcare provider.

Signed: _____ Date: _____

I authorize to release medical information required to process my claim.

Signed: _____ Date: _____

I have read and understand the Financial Policy for Platte Valley Clinic.

Signed: _____ Date: _____

I authorize to obtain/have access to my medication history.

Signed: _____ Date: _____

I authorize my provider's office to contact me by cell phone

Signed: _____ Date: _____