# NEUSE VALLEY INTERNAL MEDICINE
# REGISTRATION / ANNUAL UPDATE

*(Please print)*

| Today's date: | PCP: |
|---|---|

## PATIENT INFORMATION

| Last Name | First Name | Middle Name |
|---|---|---|
| | | |

| Mailing Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

| SSN | DOB | Sex | Marital Status |
|---|---|---|---|
| | | M F | Single Married<br>Divorced Widowed |

| Home phone # | Mobile phone # | Email address |
|---|---|---|
| | | |

| Preferred Method of Contact | Is it okay to leave a message if phone is your preferred method of contact? | Preferred Language | Do you have a patient portal |
|---|---|---|---|
| Home Cell Portal | Y N | | Y N |

## INSURANCE INFORMATION

***(PLEASE GIVE YOUR INSURANCE CARDS TO THE RECEPTIONIST)***

**PRIMARY INSURANCE**

| Plan Name | Policy/ID # | Group | Effective Date |
|---|---|---|---|
| | | | |

| Plan Mailing Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

**IF SUBSCRIBER IS NOT THE PATIENT, PLEASE COMPLETE THIS SECTION**

| Subscriber Last Name | Subscriber First Name | Subscriber Middle Name |
|---|---|---|
| | | |

| Subscriber SSN | Subscriber DOB | Subscriber Sex | Subscriber Phone # |
|---|---|---|---|
| | | M F | |

| Subscriber Mailing Address (if different from above) | City | State | Zip Code |
|---|---|---|---|
| | | | |

## EMERGENCY CONTACT

| Name | Relationship to patient | Contact # |
|---|---|---|
| | | |

The information above is true to the best of my knowledge. I authorize my insurance benefits be paid directly to my provider. I authorize Neuse Valley Internal Medicine to release information required to process my claim. I also agree that I will be financially responsible for any balance not paid by my insurance benefits.

| Signature | Date |
|---|---|
| | |