Holvik Family Health Center
221 E. Caldwell Ave. Visalia, Ca 93277
(559) 732-4726 Fax (559) 732-4747

PATIENT REGISTRATION FORM

Patient Name: (As Appears on Insurance Card)	Date:
Address:	Account:
City, State, Zip:	Date of Birth:

Sex: Male Female Marital Status:	Primary Phone #:
Email Address:	Cell Phone #:
Driver's License/ID #:	Work Phone#:
Employer:	Social Security #

Emergency Contact/Phone #:	Relation:

PRIMARY INSURANCE: ____________________

Policy Holder Name:	
Policy Holder Date of Birth:	
ID or Subscriber #:	
Group #:	
Copay:	

SECONDARY INSURANCE: ____________________

Policy Holder Name:	
Policy Holder Date of Birth:	
ID or Subscriber #:	
Group #:	
Copay:	

I authorize the use of this information for the following purposes: to bill my insurance companies, to process my labwork and/or radiology, and to assist in my treatment with other healthcare professionals.

Signature____________________ Date: ______

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