



Valley Surgical Specialists

A MEMBER OF COMMUNITY FOUNDATION MEDICAL GROUP & PART OF SANTE HEALTH FOUNDATION

Valley Surgical Specialists Medical Group
BSV Medical Pavilion
782 Medical Center Drive East #101
Clovis, CA 93611
(559) 256-4111

Phone Instruction

In order to provide the quickest response to your questions and at the same time protect your privacy, please take a few moments to let us know how you would like us to contact you regarding your lab results and health care questions.

TELEPHONE ANSWERING MACHINE AT HOME:

DO NOT leave messages on answering machine

DO leave messages for me to call

PEOPLE AT HOME:

DO NOT leave messages

DO leave messages for me to call **BUT NO RESULTS**

WORK:

DO NOT CALL ME AT WORK

DO call at work leaving a message to call only

OTHER:

I would like to have calls and my lab results handled in the following manner:

I have read the Notice of Patient Privacy Practice. I have been given the opportunity to receive a copy of this policy which details how my health/account information be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information. I understand that the above request will remain in effect until I request a change and fill out another form.

Signature: _____ Date: _____



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Valley Surgical Specialist Medical Group Patient Registration Form

A Member Of Community Foundation Medical Group & Sante Health Foundation

Please print. Present Photo ID and Insurance cards for registration. Account Number: (office use only)

Form section for personal information including name, address, phone numbers, social security, date of birth, race, and ethnicity.

Form section for employment information including status (Self Employed, Unemployed, etc.) and employer details.

Form section for medical history including Referring Physician, Primary Care Physician, and Pharmacy Name.

Form section for emergency contact information including name, phone, and relationship.

Form section for dependent information including relationship, full name, date of birth, and address.

Form section for insurance information including primary and secondary insurance company details.

I verify that this information is true and correct as of this date.

Signature: Date: