

Andrew S. Cook, MD  
Linda Mavity, NP, NCMP



14830 Los Gatos Blvd., Suite 300  
Los Gatos, CA 95032  
Tel (408) 358-2511  
Fax (408) 358-1009  
www.vitalhealth.com

### PATIENT REGISTRATION FORM

How did you hear about Vital Health Institute? \_\_\_\_\_ Date: \_\_\_\_\_  
TIME ZONE: \_\_\_\_\_  IN  OUT \_\_\_\_\_

Name: _____	Preferred Name in the Office: _____
Address: _____	City: _____ State: _____ Zip: _____
SSN: _____	Birth Date: _____ Age: _____

Mobile #: _____ <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Msg ok?	Home #: _____ <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Msg ok?	Work #: _____ <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Msg ok?
Fax _____	Email: _____	
SKYPE or FaceTime ID: _____	Preferred appointment reminder method? <input type="checkbox"/> Telephone <input type="checkbox"/> Email	
Mailing Address: _____ (If different than residence address)		
Emergency Contact: _____	Relationship: _____	Tel #: _____

EMPLOYMENT INFORMATION:
Occupation _____ Employer: _____ # of years: _____

SPOUSE / SIGNIFICANT OTHER INFORMATION:
Name: _____ Work#: _____ Mobile #: _____
Occupation _____ Employer: _____

INSURANCE INFORMATION: <i>I certify that, I, and / or my dependents (s) have insurance coverage with:</i>
Insurance Carrier: _____ <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> HSA <input type="checkbox"/> HMO <input type="checkbox"/> Other: _____
Is this an Obama Health Care Plan? NO, if YES, Circle Tier Level: Bronze Silver Gold Platinum
Name of Primary Subscriber on the Plan: _____ Relationship to Patient _____
Date of Birth & SSN of Primary: _____ Insurance Tel#: _____
ID# _____ Group# _____
Claims Address: _____
_____

Who is financially responsible for all charges whether or not paid by insurance: \_\_\_\_\_  
Contact Information: Tel: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

I authorize the use of my signature on all insurance submissions. I assign directly to Vital Health Institute ("VHI") all insurance benefits, if any, otherwise payable to me for services rendered. VHI may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I understand that VHI will submit claims to my Primary Insurance Carrier only; I will be responsible for submitting to a Secondary Insurance Carrier, if applicable. \_\_\_\_\_ Initial