CUCAMONGA VALLEY™
MEDICAL GROUP

Patient Registration

Welcome to Cucamonga Valley Medical Group. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent.

Patient Information

PATIENT'S FIRST AND LAST NAME | MIDDLE INITIAL | TODAY'S DATE | DATE OF BIRTH | AGE | GENDER (M / F)

PARENT'S FIRST AND LAST NAME (IF PATIENT IS A MINOR) | PATIENT'S RACE | MARITAL STATUS

PATIENT'S SOCIAL SECURITY NUMBER | PATIENT'S DRIVER'S LICENSE NUMBER

HOME ADDRESS | CITY | STATE | ZIP CODE

MAILING ADDRESS (WRITE "SAME" IF SAME AS HOME) | CITY | STATE | ZIP CODE

HOME PHONE | CELL PHONE

WORK PHONE | EXT. | EMAIL ADDRESS

OCCUPATION | EMPLOYER'S NAME (SCHOOL NAME IF FULL-TIME STUDENT)

EMPLOYER'S ADDRESS (SCHOOL ADDRESS IF FULL-TIME STUDENT) | CITY | STATE | ZIP CODE

HOW DID YOU HEAR ABOUT OUR PRACTICE?

Emergency Contact Information: Who We Should Notify in Case of Emergency

PRIMARY CONTACT (FIRST AND LAST NAME) | MIDDLE INITIAL | RELATIONSHIP TO PATIENT

ADDRESS | CITY | STATE | ZIP CODE

HOME PHONE | WORK PHONE

Guarantor Information: Person Responsible For Fees / Insured Party / Legal Guardian

NAME | RELATIONSHIP TO PATIENT

ADDRESS | CITY | STATE | ZIP CODE

HOME PHONE | CELL PHONE | WORK PHONE

INSURANCE COMPANY | CLAIM ADDRESS

SUBSCRIBER'S NAME | **SUBSCRIBER'S DATE OF BIRTH** | **SUBSCRIBER'S SOCIAL SECURITY NUMBER**

INSURANCE ID NO.

SECONDARY INSURANCE | CLAIM ADDRESS

SUBSCRIBER'S NAME | **SUBSCRIBER'S DATE OF BIRTH** | **SUBSCRIBER'S SOCIAL SECURITY NUMBER**

☐ Yes ☐ No — WERE YOU INJURED ON THE JOB?

☐ Yes ☐ No — HAVE YOU INFORMED YOUR EMPLOYER?

16465 Sierra Lakes Parkway Suite 300 | Fontana, CA 92336
1310 San Bernardino Road Suite 105 | Upland, CA 91786
12442 Limonite Avenue Suite 205 | Eastvale, CA 91752
17264 W. Foothill Boulevard Suite A | Fontana, CA 92335

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