



**VALLEY INTENSIVISTS, PULMONOLOGISTS AND
SLEEP SPECIALISTS**

1200 E. Savannah Ave. Suite 12
McAllen, TX 78503
Tel: (956) 688-6300 Fax: (956) 688-6303

PATIENT REGISTRATION FORM

Please print clearly and complete all applicable fields.

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

Gender: Male Female Other Prefer not to say

Address: _____

City: _____ State: _____ Zip Code: _____

Cell #: _____ Alternate Phone #: _____

Email: _____

(Used for appointment reminders, communication and Patient Portal Access)

Preferred Method of Contact: Call Text Email

Employer: _____ Work Phone: _____

Referring Physician: _____

RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)

Full Name: _____ Date of Birth: _____

Relationship to Patient: _____ Phone: _____

Address: _____

Employer: _____ Work Phone: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Phone: _____



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PHARMACY INFORMATION:

Pharmacy Name: _____ Location (City): _____

Phone Number: _____

ACKNOWLEDGMENT:

I certify that the information provided is accurate and complete to the best of my knowledge.

Patient Signature

Date