VALLEY LASER AND SURGERY CENTER, INC.
36 W. Yokuts Avenue, Suite 3 Stockton, CA 95207
(209)952-1189 Fax (209)952-1174

Patient Information

Please print your name as it appears on your insurance card. Today's Date_____

Last Name_____ First Name_____

Middle Name_____ Date of Birth_____

Home Phone Number_____ Work Phone Number_____

Mobile Phone Number_____ Email_____

Home Address: Street_____

City_____ State_____ Zip Code_____

Mailing Address: □ Mark here if same as Home Address.
Street_____
City_____ State_____ Zip Code_____

Sex: □ Male □ Female □ Other
Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Other □ Uknown □ Decline to State
Race: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White □ Other □ Uknown □ Decline to State

Social Security Number _____

Primary Insurance_____ ID#_____

Secondary Insurance_____ ID#_____

Relationship to Insured: □ self □ through spouse or other_____
If through spouse or other, please provide Insured information:
Name_____ Date of Birth_____

Employer_____

Marital Status: □ Single □ Married □ Divorced □ Widowed Spouse's Name_____

Primary Care Provider_____ Phone Number_____

In case of an emergency, please notify:

Name_____ Relationship_____ Phone Number_____
□ OK to share my health information with this person

Name_____ Relationship_____ Phone Number_____
□ OK to share my health information with this person