



Illinois Valley Community Hospital
925 West Street, Peru, Illinois 61354
815-223-3300

Pre-Registration Form

General Information -

Have you ever been a patient at IVCH before? _____ When? _____

Service(s) you are pre-registering for: _____

Patient's Name: _____

Birth date: _____ Social Security #: _____

Patient Address: _____

Telephone #: _____ Marital Status: _____

Religion: _____ Church you Attend: _____

* * * * *

Your Employer: _____

Employer Address: _____

Employer Phone #: _____

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In case of Emergency, notify: _____

Relationship: _____

Address: _____

Phone #: _____

Financial Information -

Primary Insurance: _____

Policyholder: _____

Policyholder Date of Birth: _____

Relationship to patient: _____

Claim Address: _____

Certificate #: _____

Group #: _____

* * * * * * * * * * * *

Secondary Insurance: _____

Policyholder: _____

Policyholder Date of Birth: _____

Relationship to patient: _____

Claim Address: _____

Certificate #: _____

Group #: _____

To assist us in processing your insurance claim accurately, please bring your insurance card(s) with you when you come in for service(s).

Please drop this completed form off at IVCH

or mail the form to:

IVCH Registration

925 West St.

Peru, IL 61354

or fax the form to IVCH at 815-224-6759

Thank you!