

Patient Registration

Patient Information

Please use your full name as it appears on your insurance or Medicare Card, no Nicknames.

Last Name _____	First Name _____	MI _____
Address _____ City/State/Zip _____		
Home Phone _____	Work Phone _____	Ext. _____
Birth Date _____	Sex M/F _____	Married/Single/Other _____
Employer _____		Soc. Sec. _____
Spouse's Name _____		
Emergency Contact & Phone _____		Physician _____

Guarantor(Responsible for Account)

Last Name _____	First Name _____	MI _____
Address _____ City/State/Zip _____		
Home Phone _____	Work Phone _____	Ext _____
Birth Date _____	Sex M/F _____	Married/Single/Other _____
Soc. Sec. _____		

Insurance Information(COPY CARD(s) FRONT & BACK)

Primary Insurance Company _____		Policy # _____
Group # _____	Relationship to Patient _____	Effective Date _____
Policy Holder's Last Name: _____		First _____ MI _____
Sex M/F _____	Birthdate _____	Home Phone _____ Work Phone _____
Employer _____	Co Pay \$ _____	Referral Needed? Y N
Secondary Insurance Company _____		Policy # _____
Group # _____	Relationship to Patient _____	Effective Date _____
Policy Holder's Last Name _____		First _____ MI _____
Sex M/F _____	Birthdate _____	Home Phone _____ Work Phone _____
Employer _____	Co Pay \$ _____	Referral Needed ? Y N

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I authorize my insurance benefits (including Medicare) to be paid directly to Medical Associates of Yakima for services rendered. I also authorize Medical Associates of Yakima to release any information requested by the insurance company with regard to payment of benefits.

PATIENT'S SIGNATURE (OR LEGAL GUARDIAN)

(DATE)