

Family Medicine of Yakima an Office of Memorial Physicians, PLLC

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 _____ Cell Phone _____ Physician _____

Birth Date _____ Sex M/F Married Single Other Soc. Sec # _____ - _____ - _____

Employer _____ Spouse's Name _____

Emergency Contact Name _____ Emergency Phone _____

Guarantor (Responsible for Account)

Last Name _____ First Name _____ MI _____

Address _____ City/State/Zip _____

Home Phone _____ Work Phone _____

Birth Date _____ Sex: M F Married Single Other Soc. Sec.# _____ - _____ - _____

Patient has no insurance, is private pay. Patients Signature (Or Legal Guardian): _____

Date: _____

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

PRIMARY Insurance Company _____ Subscriber ID _____

Group ID _____ 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 _____ Subscriber ID _____

Group ID _____ 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 Memorial Physicians, PLLC for services rendered. I also authorize Memorial Physicians, PLLC on behalf of _____ to release any information requested by the insurance company with regard to payment of benefits.

I _____ the parent/legal guardian of _____ authorize & consent to routine & emergency medical services to be performed for my child when deemed necessary by qualified medical personnel. This authorization will be in effect until revoked in writing by me.

I authorize Memorial Physicians, PLLC or any collection agencies it uses to contact me by my cellular telephone for billing activities or payment arrangements.

Patient's Signature (Or Legal Guardian)

Date