Yorktown Health
Women's Personalized Care

Patient Registration Form

Name: _____

Address: _____

City: _____ State: _____ Zipcode: _____

Patient SSN: _____-_____-_____

Patient DOB: _____

E-mail Address: _____

Home Phone Number: _____ Cell Phone Number: _____

Work Phone Number: _____

May we leave a message on all numbers listed above? YES:_____NO:_____

Emergency Contact: _____

Relationship to Patient: _____

Phone Number: _____

With Whom May We Discuss Your Healthcare With?

Name: _____ Relationship: _____

Local Pharmacy Information

Name: _____City: _____Phone Number: _____

Mail Order Pharmacy Name: _____

Primary Insurance Company: _____

Primary Policy Holder Name: _____

Primary Policy Holder SSN: _____-_____-_____DOB: _____

Primary Policy Holder Employer: _____

Employer's Address: _____ City:_____ State: ____ Zipcode: _____

Employer's Phone Number: _____

*****I UNDERSTAND THAT ONCE MY CLAIM IS SUBMITTED TO MY INSURANCE COMPANY, NO CHANGES CAN BE MADE. PLEASE INFORM YOUR PHYSICIAN OF ANY SPECIAL CIRCUMSTANCES WITH THE DIAGNOSIS AT THE TIME OF YOUR VISIT*****

*****I UNDERSTAND THAT IF MY ACCOUNT GOES TO A COLLECTION AGENCY FOR NON PAYMENT, A FEE OF 50% OR LESS WILL BE ADDED TO MY BALANCE*****

*****I AUTHORIZE PAYMENT FOR MEDICAL BENEFITS FROM ALL MY INSURANCE PLANS TO BE MADE DIRECTLY TO YORKTOWN HEALTH*****

***** I UNDERSTAND THAT I AM RESPONSIBLE TO PAY NON-COVERED SERVICES AND I HEREBY AUTHORIZE THE RELEASE OF PERTINENT MEDICAL INFORMATION TO INSURANCE CARRIERS*****

SIGNATURE: _____ DATE: _____