YOUR DOC'S IN PATIENT REGISTRATION FORM (all clinics)

Date: ________________________

How may we help you today? ____

Is your treatment today, a result of a: ○ Motor Vehicle Accident ○ Work accident ○ Neither If work-related, date of accident _____________

Birth date: ____/____/_______

Name: (Last) _________________________ (First) ______________________ (Middle) _____________________ (Suffix) _____

Sex ○ Male ○ Female Social Security #: ________ - ________ - ________

Maiden Name (if applicable) ____

Mailing Address: ____ City, State, Zip: ________________________________

Personal e-mail address: ____

E-mail address for information we send to your patient portal acct: □ same as e-mail listed above Other ___________________________

Primary Care Physician (PCP): ____ Location ____________________________

Note we will fax a copy of the encounter note from today's visit to your PCP for patients within our geographic area.

Home Phone #: ( )_______________ Cell Phone #: ( )_______________ Work Phone #: ( )_______________

Which is your preferred phone?: ○ Home ○ Cell ○ Work If we cannot get hold of you, is it ok if we leave a voicemail? ○ Yes ○ No

Preferred Language: ○ English ○ Spanish ○ Indian ○ Chinese ○ Korean ○ Other __________________________

Race: (check all that apply) ○ American Indian ○ Asian ○ Black/ African American ○ Native Hawaiian/ Pacific Islander ○ White ○ Declined

Ethnicity: ○ Hispanic or Latino ○ Not Hispanic or Latino ○ Declined

Emergency Contact: ____ Relationship to patient: _______________________

Phone: ( ) _________________________________

Confidential Communication of Personal Health Information [Please indicate individual, aside from yourself, if any, authorized to speak with staff from Your Doc's In regarding the patient's evaluation, diagnosis, treatment and billing]

Name: ____ Relationship: ________________________ Initials: ________

Employer: ____

Employer Contact: ____ Employer contact #: _____________________

Workers Comp Carrier (if work-related): ____ Claim#: __________________________

WC Adjustor: ____ Adjustor Ph#: _______________________________

Lab Preference: ○ Labcorp ○ Quest **Patients are responsible for determining their preferred lab, based on their insurance. If no preference is selected, we will forward outside labwork to Quest.**

Primary Insurance: ____

Name of Policyholder (if different than patient): ___________________________________ Sex (if different than patient): ○ Male ○ Female

Policyholder address (if different than patient):____

Relationship (to patient): ○ Self ○ Spouse ○ Child ○ Other Social Sec # (if different than patient): _____ -_____ - ________

Employer (if different than patient): ____Birth date (if different from patient) : ____/____/________

Secondary Insurance Name: ____

Name of Policyholder (if different than patient): ___________________________________ Sex (if different than patient): ○ Male ○ Female

Policyholder address (if different than patient):____

Relationship (to patient): ○ Self ○ Spouse ○ Child ○ Other Social Sec # (if different than patient): ____ -____ - _______

Employer (if different than patient): ____Birth date (if different from patient) : ____/____/________

How did you hear about us? ○ Family ○ Friend ○ Relative ○ Primary Care Physician ○ TV commercial ○ Employer ○ Delmar billboard ○ Rte. 13 Carroll St near S curve billboard ○ Chincoteague billboard ○ New Church billboard ○ Rte 50 Berlin billboard ○ Website search ○ Existing patient Other ____

FOR OFFICE USE ONLY

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YDI staff initials

	DUE	PAID			
Bay Area	$______________	______________	CA	CC	CK# ________
Current Balance	______________	______________	CA	CC	CK# ________
Copay	______________	______________	CA	CC	CK# ________
Self Pay deposit (circle)	$100 (Pocomoke clinic only)	$150	CA	CC	CK# ________