

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

	DUE	PAID	
_____	Bay Area \$ _____	_____	CA CC CK# _____
YDI staff initials _____	Current Balance _____	_____	CA CC CK# _____
	Copay _____	_____	CA CC CK# _____
	Self Pay deposit \$150 _____	_____	CA CC CK# _____