YOUR DOC'S IN PATIENT REGISTRATION FORM (NON-OH OR WC)

Date: _____ Have you been here before? ◯ Yes ◯ No

How may we help you today? _____

Is today's visit, a result of a: ◯ Motor Vehicle Accident ◯ Work Injury ◯ None If yes, date of accident:

Birth Date: ____/___/_____ Sex: ◯ Male ◯ Female Social Security #: _____-____-_____

Name: (Last)_____ (First)_____ (Middle)_____ (Suffix)_____

Maiden Name:(if applicable)_____ Confidential E-mail:_____

Mailing Address:_____Apt#_____ City:_____ State/Zip: _____

Home Phone: (____) ____-_____ Cell Phone: (____) ____-_____ Work Phone: (____) ____-_____

Which is your preferred phone?: ◯ Home ◯ Cell ◯ Work May we leave a voicemail if you do not answer? ◯ Yes ◯ No

Primary Care Physician(PCP):_____ Phone#: (____) ____-_____

PCP Office Location:_____ Fax#: (____) ____-_____

Emergency Contact: _____ Relationship to Patient:_____

Home Phone: (____) ____-_____ Cell Phone: (____) ____-_____ Work 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 patients' evaluation, diagnosis, treatment and billing.]

Name:_____ Relationship:_____Initials:_____

Employer Name and Location: _____

Employer Contact:_____ Employer Phone #: (____) ____-_____

Worker's Comp Carrier(if work-related):_____ Claim #: _____

WC Adjustor: _____ Adjustor Phone #: (____) ____-_____

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:_____ Policy #: _____

Name of Policyholder(if different than patient):_____ Sex: ◯ Male ◯ Female

Policyholder Address(if different than patient):_____

Relationship to Patient: ◯ Self ◯ Spouse ◯ Parent ◯ Other Social Security #: _____-____-_____

Employer(if different than patient):_____ Birth Date: ____/___/_____

Secondary Insurance:_____ Policy #: _____

Name of Policyholder(if different than patient):_____ Sex: ◯ Male ◯ Female

Policyholder Address(if different than patient):_____

Relationship to Patient: ◯ Self ◯ Spouse ◯ Parent ◯ Other Social Security #: _____-____-_____

Employer(if different than patient):_____ Birth Date: ____/___/_____

Preferred Language: ◯ English ◯ Spanish ◯ Other:_____

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

Ethnicitiy: ◯ Hispanic or Latino ◯ Non-Hispanic or Latino ◯ Declined

FOR OFFICE USE ONLY		DUE	PAID	(Circle method)
	Bay Area	$_____	$_____	CA CC CK# _____
	Current Balance	$_____	$_____	CA CC CK# _____
	Copay	$_____	$_____	CA CC CK# _____
YDI STAFF INITIALS_____	Self Pay Deposit	$ 150	$_____	CA CC CK# _____