YUMA CARDIOLOGY ASSOCIATES / PATIENT REGISTRATION FORM

Today's Date:		Patient's Primary Care Physician or Clinic Name	

PATIENT INFORMATION

Please Print

Patient's Last Name	Patient's First Name	Middle Initial	Mr. ___ Mrs. ___	Miss ___ Ms. ___	Patient's Marital Status (Circle One): Single	Married	Divorced	Separated	Widowed

Is this Patient's legal name? Yes	No	If no, legal name:	Former Name(s) (please list all)	Patient's Birth Date: Mo.	Day	Year	Age:	Patient's Sex (Circle One): Male	Female

Patient's Street Address:	Social Security No.	Primary Phone	Secondary Phone
		( )	( )

P.O. Box:	City:	State:	Zip Code:

Patient's Occupation:	Employed by:	Employer Phone
		( )

Patient chose clinic because / Patient was referred to Clinic by *Please select one or fill in here:*	Clinic/Doctor	Insurance Plan	Hospital

PATIENT PREFERENCES

Please Print

Communication Preference: (Circle One) MyCare *Patient Portal*	Email *Please provide email address*	Mail *Will send to Patient's Address above*	Email Address:	Preferred Primary Language:	Interpreter Needed: Yes	No	Preferred Pharmacy Name:	Preferred Pharmacy Location *(Please be as specific as possible):*

(Optional) Ethnicity:		(Optional) Religious Preference:	

PAYMENT & INSURANCE INFORMATION

Please Print

Person Responsible for Bill (*Guarantor*):	Birth Date: Mo.	Day	Year	Address (if different from Patient):	Home Phone No:
					( )

Is this person a patient here? *(Circle one)* Yes	No	Occupation:	Employed by:	Employer Address:	Employer Phone No.
					( )

PRIMARY INSURANCE If Applicable — *Please provide your insurance card to the receptionist*

Patient's PRIMARY Insurance Name:	Group Number:	Policy Number:	Co-Payment:

Who provides insurance? (Subscriber):	Subscriber's Social Security No.	Subscriber's Birth Date: Mo.	Day	Year

Patient relationship to subscriber (circle one):	Self	Spouse	Child	Other

SECONDARY INSURANCE If Applicable — *Please provide your insurance card to the receptionist*

Patient's SECONDARY Insurance Name:	Group Number:	Policy Number:	Co-Payment:

Who provides insurance? (Subscriber):	Subscriber's Social Security No.	Subscriber's Birth Date: Mo.	Day	Year

Patient relationship to subscriber (circle one):	Self	Spouse	Child	Other

EMERGENCY CONTACT Information

Please Print

Name of Local Friend or Relative:	Relationship to Patient:	Primary Phone No.	Secondary Phone No.
		( )	( )
Name of Local Friend or Relative:	Relationship to Patient:	Primary Phone No.	Secondary Phone No.
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Yuma Cardiology Associates or insurance company to release any information required to process my claims.

Patient / Guardian Signature:	Date: