Memorial Primary Care
York Heart and Vascular Specialist

PATIENT REGISTRATION DOCUMENT

Date _____ / _____ / _____ How were you referred to our practice? ____________________

PATIENT INFORMATION
Last Name ____________________ First Name ____________________ MI _____
Address ____________________ City ____________________ State _____ Zip _______
Phone (_____) ______________ S.S. # ________-_______-________ Date of Birth _____ / _____ / _____
Sex ☐ Male ☐ Female Marital Status ____________________

EMPLOYMENT STATUS Employed ☐ Yes ☐ No Student ☐ Yes ☐ No
Employer ____________________ Occupation ____________________
Address ____________________ City ____________________ State _____ Zip _______
Phone (_____) ______________

GUARANTOR INFORMATION (if different from Patient)
Last Name ____________________ First Name ____________________ MI _____
Address ____________________ City ____________________ State _____ Zip _______
Phone (_____) ______________ S.S. # ________-_______-________ Date of Birth _____ / _____ / _____
Sex ☐ Male ☐ Female Marital Status ____________________

INSURANCE INFORMATION
Primary Insurance ____________________ Cardholder ____________________
I.D. # ______________ Group # ______________ Plan ____________________
Claims Address ____________________
Patient relationship to cardholder ____________________
Cardholder Date of Birth _____ / _____ / _____ S.S. # ________-_______-________ Sex ☐ Male ☐ Female
Employer ____________________
Secondary Insurance ____________________ Cardholder ____________________
I.D. # ______________ Group # ______________ Plan ____________________
Claims Address ____________________
Patient relationship to cardholder ____________________
Cardholder Date of Birth _____ / _____ / _____ S.S. # ________-_______-________ Sex ☐ Male ☐ Female
Employer ____________________

EMERGENCY CONTACT Name ____________________ Relationship ____________________
Phone (_____) ______________

ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I authorize the release of any medical information necessary to process insurance claims or any medical information that is needed for any utilization review or quality assurance activities. I assign all medical and/or surgical benefits to which I am entitled to ____________________ . This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I am responsible for the payment of this account regardless of insurance coverage.

Signature ____________________ Date _____ / _____ / _____
Relationship if not patient ____________________
Patient unable to sign due to ____________________
I, ____________________ , parent or legally responsible party of, ____________________
authorize ____________________ to render emergency medical treatment to the above individual in the event I am unable to be present at the time this care is needed.