YAKIMA VASCULAR ASSOCIATES
A Member of MEMORIAL'S Family of Services

Yakima Vascular Associates
3999 Englewood Avenue, Suite 202, Yakima, WA 98902 • Phone – 509.453.4614 • Fax – 509.453.3468

Patient Registration

Patient Information

Please use your full name as it appears on your insurance or Medicare Card. No Nicknames.

Last Name_____ First Name_____ MI _____

Address_____ City/State/Zip_____

Home Phone_____ Work Phone_____ Physician_____

Birth Date_____ Sex: M F Married Single Other Soc. Sec.#_____

Employer _____ Pharmacy_____

Emergency Contact_____ Emergency Phone_____

Guarantor (Responsible for Account)

Last Name_____ First Name_____ MI _____

Address_____ City/State/Zip_____

Home Phone_____ Work Phone_____

Birth Date_____ Sex: M F Married Single Other Soc. Sec.#_____

Insurance Information (COPY CARD(s) FRONT & BACK)

Primary Insurance Company_____Subscriber ID_____

Group ID_____ Relationship to Patient_____ Effective Date_____

Policy Holder Last Name_____ First_____ MI_____

Sex: M F Birth Date _____ Home Phone_____ Work Phone_____

Employer_____ Co Pay $_____ Referral Needed? Y N

Secondary Insurance Company_____Subscriber ID_____

Group ID_____ Relationship to Patient_____ Effective Date_____

Policy Holder's Name_____ First_____ MI_____

Sex: M F Birth Date _____ Home Phone_____ Work Phone_____

Employer_____ Co Pay $_____ Referral Needed? Y N

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I authorize my insurance benefits (including Medicare) to be paid directly to Memorial Practice Management, on behalf of Yakima Vascular Associates, for services rendered. I also authorize Memorial Practice Management to release any information requested by the insurance company with regard to payment of benefits.

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Patient's Signature (Or Legal Guardian) Date Printed Name of Guardian (if applicable)