



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 Spouse's Name
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.

Patient's Signature (Or Legal Guardian) Date

Printed Name of Guardian (if applicable)