Pediatric
ASSOCIATES OF YORK HOSPITAL

PLEASE COMPLETE THE ENTIRE REGISTRATION FORM AND PROVIDE YOUR HEALTH INSURANCE CARD

DATE: ______________________

Last Name: _____________________ Middle Initial: ___ First Name: ___________________________

Date of Birth: _________________ Sex: ☐ M ☐ F Social Security Number: _________________

Patient's Mailing Address: ____
Street Address /PO Box City State Zip Code

Is your mailing address the same as your physical address? ☐ Yes ☐ No

If no, please provide physical address: ____

Home Phone: __________________ Work Phone: ______________ Cell Phone: __________________

Fax #: ______________ Email: ____

Patient's Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered

Spouse / Partner's Name: ______________________ Spouse/Partner's Phone: ______________________

COMMUNICATION PREFERENCE (general communication between patient and office):

☐ Printed ☐ Portal ☐ Phone ☐ OK TO MAIL Can we leave messages on your voicemail? ☐ Yes ☐ No

Are you hearing impaired? ☐ Yes ☐ No ***If yes***, do you require any additional services to ensure you are provided the appropriate care: ____

AUTHORIZATION TO DISCLOSE INFORMATION: I give [*YH*] permission to speak to (Please provide name and phone number) ____ regarding my ☐ **medical information** AND/OR ☐ **billing information.**

Employment status: ☐ Full ☐ Part-time ☐ Unemployed ☐ Student ☐ Retired

Employer Name:_______________________________Occupation:_________________________________

Emergency Contact Name: ________________________________ Relationship:_____________________

Emergency Contact Phone: ________________________________

Primary Care Physician: ________________________ Preferred Pharmacy: ________________________

Primary language: ___________________________ Do you require a translator? ☐ **Y** ☐ **N**

See below: The Maine Health Data Organization is requiring all health care professionals to collect data about your background which includes your race, ethnicity and language preference. The purpose of this is to ensure that all patients receive high quality care.

Race:
☐ White/Caucasian ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian /Other Pacific Islander ☐ Hispanic ☐ Refuse to Report ☐ Other: _______________

Ethnic categories:
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown ☐ Refuse to Report

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PLEASE PROVIDE YOUR INSURANCE CARD AT EACH VISIT
IF YOU ARE AGE 18 OR OVER, PATIENT STATEMENTS WILL BE MAILED TO YOU

PRIMARY Insurance Name:______________________________Policy # __________________________

Group #: _______________ Policy holder (guarantor) Name:____________________________ ☐ **SELF**

Address of policy holder (guarantor):____ ☐ Same as home address

Home phone: (____)-_______-_______ DOB of policy holder (guarantor): ____/_____/____

SSN _____-_______-______ Relationship of guarantor to patient:_____________________________________

Employer name of policy holder (guarantor):____

SECONDARY Insurance Name:______________________________Policy # __________________________

Group #: _______________ Policy holder (guarantor) Name:____________________________ ☐ **SELF**

PLEASE CONTACT YOUR INSURANCE COMPANY TO CHANGE YOUR PCP IF YOU ARE REQUIRED TO CHOOSE A PRIMARY CARE PROVIDER.

- I consent to diagnostic tests, treatments, or planned recurring treatments that the physicians/practitioner (provider) deems necessary. This may also include emergency care if the provider deems necessary.
- I understand that I have the right to be informed about the risks, benefits and the alternatives to any care, treatment procedure before I receive it.
- I have the right to accept or refuse any medical or surgical care, treatment or procedure.
- I authorize release of prescription eligibility and prescription history to be obtained via EMR by ***York Hospital***.
- I authorize release of information needed to continue my care or to determine benefits for the services rendered.
- I request that all payment of authorized benefits be made directly to York Hospital and all physicians or other professionals involved in my care.
- I acknowledge that I am financially responsible for any co-pay, coinsurance, deductible, denied or any outstanding balances relating to my health care. I am responsible for providing by ***York Hospital*** with the most current insurance information. I further understand that if I do not provide my current insurance, I may be asked to sign an insurance waiver stating that I may be responsible for payment of service, if insurance was not provided at the time of visit.
- In the absence of appropriate referrals or pre-authorization, you agree to accept full responsibility for any charges related to the service performed by York Hospital.
- I am aware that the York Hospital Privacy Notice Booklet has further information about how medical information may be used and disclosed. I have had the opportunity to receive and review this booklet and may request an updated copy at any time.
- I have been given / offered a copy of York Hospital's Patient's Right's Notice.

____ ______________________________
Patient Signature Date