Yale NewHaven Health Northeast Medical Group

PATIENT REGISTRATION FORM

SECTION 1: PATIENT INFORMATION

_____
Last Name First Name Mid. Initial

Social Security #: _____ Date of Birth: _____ Gender: M / F

Marital Status: ☐Married ☐Single ☐Widowed ☐Divorced ☐Legally Separated

Mailing Address: _____

City: _____ State: _____ Zip: _____

Street Address (*if different than above*): _____

Email Address: _____

Phone #1 (Primary): _____ ☐Home ☐Cell ☐Work

Phone #2 (Alternate): _____ ☐Home ☐Cell ☐Work

Primary Care Provider (PCP): _____ Referring Provider: _____

SECTION 2: GUARANTOR INFORMATION *(Person who has financial responsibility)*

Guarantor's Name: _____ Relationship to Patient: _____

Date of Birth: _____ Phone: _____ Social Security #:_____

Guarantor's Employer: _____ Work Phone: _____

Employer's Address: _____

SECTION 3 - OPTIONAL: ***NEMG is collecting patient demographic data to assist the practice in understanding its patient population to develop the capability, where needed, to provide culturally appropriate medical care and advice.***

Please assist us by completing the following:

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race (*Mark one or more*): ☐Asian ☐African American ☐American Indian or Alaska Native
☐Native of Hawaii/Pacific Islander ☐White ☐Decline to Provide

Preferred Language: ☐English ☐Spanish ☐French ☐Dutch ☐Chinese ☐Greek ☐Hindi ☐Russian
☐Portuguese ☐German ☐Other (Please specify): _____

SECTION 4: EMPLOYMENT

Employment Status (Circle): Full Time Part Time Not Employed Retired Active Military Full-time Student Part-time Student

Employer: _____ Phone Number: _____

Employer Street Address: _____

City: _____ State: _____ Zip: _____

IS THIS A WORK OR AUTO RELATED INJURY? Yes / No / Undetermined

If yes or undetermined, please ask receptionist for additional paperwork.

SECTION 5: SUBSCRIBER INFORMATION *Please present insurance card(s) to receptionist for copying.*

PRIMARY *(Self / Significant Other / Parent or Guardian)*	**SECONDARY** *(Self / Significant Other / Parent or Guardian)*
Insurance Name: _____	Insurance Name: _____
Effective Date: _____	**Effective Date:** _____
Subscriber Name: _____	Subscriber Name: _____
Subscriber's Employer: _____	Subscriber's Employer: _____
Subscriber's Date of Birth: _____	Subscriber's Date of Birth: _____
Subscriber S.S. #: _____	Subscriber S.S. #: _____
I.D. # / Policy #: _____	I.D. # / Policy #: _____
Group/Plan #: _____	Group/Plan #: _____

If Medicare is secondary, circle reason: *Working Spouse has insurance Veteran Disabled*

Other: _____

For Office Use Only

Completed by: _____

Date Entered: _____