YORLAN PSYCHOLOGICAL ASSOCIATES, LLC.

REGISTRATION FORM

(Please Print)

Today's date:	Family Physician: Phone Number:

PATIENT INFORMATION

Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:		Email:			Home Phone: ( )
P.O. box:	City:		State:		ZIP Code:
Occupation:	Employer:				Cell Phone: ( )

Referred By: ❑ Online Site: _____ ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages

May we leave a message on your phone and/or answering machine? ❑ Yes ❑ No ❑ Other Directions: _____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill/Client:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ Highmark ❑ Capital BC ❑ OVR ❑ Quest ❑ Cigna ❑ Tricare ❑ Other:

Subscriber's name:	ID Number:	Birth date: / /	Group no.:	Co-Payment: $	Coinsurance: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Subscriber's DOB:	ID Number:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Yorlan Psychological Associates, LLC. or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

Revised 9/1/2017