Patient Registration Form

SAN FRANCISCO
VOICE & SWALLOWING
KATHERINE C. YUNG, MD FACS

Today's Date ______________________ **Medical Record** # (for office use) ______________________

DEMOGRAPHICS

Legal Name ____
Last Name First Name M.I.

Chosen name (if different)______________________ Date of Birth ____________ Age: __________

Social Security #________________________________ Gender: ☐ Male ☐ Female ☐ Other

Mailing Address ____
street apt # city state zip

Primary Phone (_______)______________ ☐ Home ☐ Work ☐ Cell

Secondary Phone (_______)______________ ☐ Home ☐ Work ☐ Cell

Email: ____

ADDITIONAL GOVERNMENT-REQUESTED INFO

Ethnicity ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown ☐ Decline to state

Race ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ Black/African American ☐ White ☐ American Indian/Alaska Native ☐ Other ☐ Unknown ☐ Decline to state

Marital Status ☐ Single ☐ Married ☐ Civil Union ☐ Divorced ☐ Widowed ☐ Comitted Relationship ☐ Domestic Partnership Living Together ☐ Domestic Partnership not Living Together ☐ Other:_______

Preferred Language ☐ English ☐ Spanish ☐ Cantonese ☐ Russian ☐ Other

Needs Interpreter ☐ Yes ☐ No **Appt Reminder Pref:** ☐ Phone ☐ Text

PRIMARY CARE PROVIDER & EMERGENCY CONTACT INFO

Primary Care Provider____

Referring Provider ***(Who referred you to our practice?)*** ______________________________

Emergency Contacts:

	Primary	**Secondary**
Name :		
Phone :	( )	( )
Relationship to Patient :		
Mailing Address (optional) :		

Please fill next page as well →

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INSURANCE INFORMATION

Do you have insurance? ☐ Yes ☐ No **If you checked no, then fill #1 below, skip #2 and sign at the bottom**

#1. Guarantor Information (person held responsible for the bill):

If the patient is responsible for the bill, skip this section, fill # 2 below for Subscriber information and sign at the bottom

Guarantor Name____ Date of Birth: _____________
(if different from patient) Last Name First Name M.I.

Social Security #___________________________________ Gender: ☐ Male ☐ Female

Phone (_______)_________________ Relationship to Patient: ___________________________

Mailing Address ____
street apt # city state zip

Employment Status ____

Employer ____

#2. Subscriber Information:

If the patient is the subscriber, please skip the next few lines, fill employment/coverage information and sign at the bottom

Subscriber Name____ Date of Birth: _____________
Last Name First Name M.I.

Social Security #___________________________________ Gender: ☐ Male ☐ Female

Phone (_______)_________________ Relationship to Patient: ___________________________

Mailing Address ____
street apt # city state zip

Employment Status: ____

Employer ____

Coverage Info:

This section can be skipped if you presented the insurance policy card to our receptionist

Coverage Name (Insurance Name):____

Insurance Policy ID for the patient :____

Insurance effective Date:___________________________ Subscriber ID:_________________________

Signature of patient or parent/guardian:	**X**	Dated: