APPOINTMENT DATE _____ TIME _____ DR. _____

REFERRED BY _____ FAMILY DR. _____

Richard S. York, M.D., P.C.
General Surgery · Endoscopy Procedures
5 Atkinson Drive, Suite 201 · Ludington, Michigan 49431 · (231) 845-7732

Welcome to my practice. Please take a moment to complete the information requested below. Please complete all sections and sign at the bottom. Thank you for your help.

PATIENT'S NAME _____ AGE _____ BIRTH DATE ___/___/___

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ PATIENT'S WORK PHONE _____

EMPLOYER _____

SOCIAL SECURITY NO. _____ PATIENT'S SEX ☐ MALE ☐ FEMALE

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

IF MARRIED, SPOUSES NAME _____ BIRTH DATE ___/___/___

SPOUSE'S EMPLOYER _____ WORK NO. _____

NEXT OF KIN (CAN BE SPOUSE) _____

IF PATIENT IS A CHILD, PERSON RESPONSIBLE FOR PAYMENT

NAME _____ RELATIONSHIP _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

EMPLOYER _____

SOCIAL SECURITY NO. _____ PHONE NO. _____

STUDENT ☐ FULL TIME ☐ PART TIME ☐ NON-STUDENT

INSURANCE INFORMATION

(Bring your cards with you)

INSURANCE NO. 1 COMPANY NAME _____

COMPANY ADDRESS _____

POLICY NO. _____ GROUP NO. _____

SUBSCRIBER'S NAME _____

INSURANCE NO. 2 COMPANY NAME _____

COMPANY ADDRESS _____

POLICY NO. _____ GROUP NO. _____

SUBSCRIBER'S NAME _____

WHO PAYS FOR YOUR SECOND INSURANCE? _____

PAYMENT AGREEMENT:
I understand that Richard S. York, M.D., P.C. will bill for all services provided me. If I do not have insurance, I agree to pay Dr. York for services provided to me. If I have health insurance which covers physician services, I understand I am responsible, if for some reason Dr. York is not paid by an insurer for the services.

MEDICAL RELEASE:
I hereby authorize Dr. York to disclose any medical records or other information pertaining to my treatment, hospitalization or out-patient services to any insurance company, employer, acting intermediary or upon patient's request to another physician or hospital. A photocopy of this authorization will be as valid as the original.

INSURANCE AUTHORIZATION:
I also authorize payment of medical benefits to be sent directly to Richard S. York, M.D., P.C. (Tax ID#38-3349688) for any services rendered. I have read this form (or have had it read to me) and I understand it. I agree that by signing this form I am bound by what it says whether I am the patient or someone acting on the patient's behalf.

Patient Signature or Responsible Party _____ Date: _____