Yale Medical Group
THE PHYSICIANS OF YALE UNIVERSITY

Greater New Haven OB/GYN Group

PLEASE COMPLETE

REGISTRATION HOURS: MON.-THURS.: 7:30 a.m. – 7:00 p.m., FRI.: 7:30 a.m.-5:00 p.m.

Fax to: **YMG Central Registration**
P.O. Box 7309
New Haven, CT 06519-0309

Fax: (203) 785-2072
Tel: (203) 785-3809
Toll Free: 1-888-639-9253

PRIMARY CARE PHYSICIAN: _____
(Doctor Name)

_____
(City) (State) (Zip)

INFORMATION ABOUT THE PATIENT: (Please complete ALL of this section)

Name: _____
(Last) (First) (Middle) (Maiden)

Address: _____
(Number & Street) (City) (State) (Zip)

Home Phone: ( ) --

Cell Phone: ( ) --

Mo | Day | Year
(Date of Birth)

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(Social Security Number)

☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Life Partner

Spouse's Name: _____
(Last) (First) (Middle)

Race: ☐ American Indian ☐ Asian ☐ Black ☐ Caucasian ☐ Spanish/Hispanic ☐ Other

Birthplace of Patient: _____

Has the patient ever received medical treatment at Yale-New Haven Hospital? ☐ Yes ☐ No

Patient's Employer: _____ Occupation: _____ ( ) _____
(Phone Number)

Employer's Address: _____
(Number & Street) (City) (State) (Zip)

PERSON RESPONSIBLE FOR BILL: (If patient is a child or a legal dependent)

Mo | Day | Year
(Date of Birth)

Name: _____
(Last) (First) (Middle)

Address: _____
(Number & Street) (City) (State) (Zip)

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Relationship of Patient: _____

Employer: _____ ( ) _____

Employer's Address: _____
(Number & Street) (City) (State) (Zip)

☐ **CHECK HERE IF SELF PAY**

CONTINUED ON OTHER SIDE

Signature _____ Date _____

If you have insurance please complete on other side

PLEASE COMPLETE APPLICABLE SECTIONS FOR YOUR INSURANCE

1 DEPARTMENT OF INCOME MAINTENANCE (T19), HMO/T19 OR CITY WELFARE

Medicaid (T19) ID: _____

Is this an HMO/T19? ☐ Yes ☐ No

If Yes, Name of Insurance. _____

ID # _____ Group # (if any) _____

City Welfare Name & No.: _____

EFFECTIVE DATE

Mo	Day	Year

2 MEDICARE

Medicare No.: | | | | – | | | – | | | | | |

Please refer to your medical card – Do you have?

Hospital Part A ____

Medical Part B ____

or both ____

EFFECTIVE DATE(s)

Mo	Day	Year

Is this insurance: ☐ Primary or ☐ Secondary

3 INSURANCE INFORMATION

Insurance Co. Name: _____

Plan Name/Contract Type: _____

Ins. Co. Address from Ins. Card: _____

Phone No.: _____

City, State, Zip: _____

Policy/Membership/ID No.: _____

Group Number (if any): _____

If Policyholder Other Than Patient _____

Subscriber's Name: _____

Subscriber's Employer: _____

Subscriber's SS#: _____

Subscriber Date of Birth: _____ ☐ Male ☐ Female

Sub Relation to Patient: _____

Is this Insurance: ☐ Primary or ☐ Secondary

EFFECTIVE DATE

Mo	Day	Year

Does This Insurance Cover Hospital Services? ☐ Yes ☐ No

4 SECONDARY INSURANCE

Insurance Co. Name: _____

Plan Name/Contract Type: _____

Ins. Co. Address from Ins. Card: _____

Phone No.: _____

City, State, Zip: _____

Policy/Membership/ID No.: _____

Group Number (if any): _____

If Policyholder Other Than Patient _____

Subscriber's Name: _____

Subscriber's Employer: _____

Subscriber's SS#: _____

Subscriber Date of Birth: _____ ☐ Male ☐ Female

Sub Relation to Patient: _____

EFFECTIVE DATE

Mo	Day	Year

Does This Insurance Cover Hospital Services? ☐ Yes ☐ No

5 IS THIS A WORKMAN'S COMPENSATION CLAIM? ☐ YES ☐ NO

Case Number: _____ Date of Injury

Mo	Day	Year

Injury Description (Neck Injury, etc.) _____

Employer at time of injury: (If different from current employer) _____

Employer Address: _____ Phone: _____

Complete section 3 with insurance carrier information.

PLEASE PROVIDE US WITH A CONTACT NAME AND PHONE NUMBER IN CASE THERE IS NEED FOR ADDITIONAL INFORMATION REGARDING YOUR WORKMAN'S COMPENSATION CLAIM.

Contact Name: _____ Phone: _____