

**PATIENT REGISTRATION**  
**-PLEASE PRINT-**

- New Patient
- Link Only
- Change (Indicate)

Account No.  Chart No.

**PATIENT DATA**

Last Name		First Name		M.I.	Maiden Name		Social Security No.			
Area Code	Telephone No.	Mailing Address			City		State	Zip		
Date of Birth	Age	Sex	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Marital	Mar. <input type="checkbox"/>	Wid. <input type="checkbox"/>	Sing. <input type="checkbox"/>	Div. <input type="checkbox"/>	Sep. <input type="checkbox"/>
Occupation	Employer	Phone		Employer's Address		City	State			
Spouse Name					Spouse Date of Birth					
In Case of Emergency – Notify		Relationship	Telephone No.		Address		City	State	Zip	
Have you or any member of your immediate family been examined here before?		Yes <input type="checkbox"/>	If Yes, give name		Have you been in the Clinic under another name?		Yes <input type="checkbox"/>	If Yes, give name		
		No <input type="checkbox"/>					No <input type="checkbox"/>			

**HEAD OF HOUSEHOLD/RESPONSIBLE PARTY/ADDRESS FOR STATEMENTS**  
 (We would prefer one account per family)

Last Name		First Name		M.I.	Social Security No.		Relationship to Patient			
							Self <input type="checkbox"/>	Spouse <input type="checkbox"/>	Parent <input type="checkbox"/>	Other <input type="checkbox"/>
Area Code	Telephone No.	Mailing Address			City		State	Zip		
Occupation		Employer		Address			Phone			

**INSURANCE INFORMATION**

**PRIMARY**

**SECONDARY**

Company Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 Effective Date \_\_\_\_\_  
 Certificate/ID Number \_\_\_\_\_  
 Employer Name/Group Number \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_  
 Subscriber Date of Birth \_\_\_\_\_  
 Pre-Cert required? No Yes Phone \_\_\_\_\_

Company Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 Effective Date \_\_\_\_\_  
 Certificate/ID Number \_\_\_\_\_  
 Employer Name/Group Number \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_  
 Subscriber Date of Birth \_\_\_\_\_  
 Pre-Cert required? No Yes Phone \_\_\_\_\_

**CONSENT AND ACKNOWLEDGEMENT RECEIPT OF NOTICE  
YANKTON MEDICAL CLINIC®, P.C.**

**CONSENT TO BLOOD TEST FOR HEALTHCARE PROVIDER PROTECTION:** To protect the healthcare team who may accidentally be exposed to my blood or body fluids, I consent to have my blood tested for transmissible disease (such as hepatitis virus, HIV (AIDS) others). If this testing is necessary it will be done at no charge. Your physician will inform you if this should become necessary.

**I AUTHORIZE MY ATTENDING PHYSICIAN TO USE AND DISCLOSE MY PERSONAL HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.**

I authorize benefits to be paid directly to the physician. I understand I am financially responsible for this bill regardless of insurance coverage. I understand that interest of 1% per month compounded annually will be added on all unpaid balances after 90 days. I acknowledge that by signing this registration that I am contracting to pay for the medical services and supplies rendered. I understand I am responsible for my spouse/dependents charges.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

I, \_\_\_\_\_ the parent or legal guardian of my child, authorize and consent to routine and emergency medical treatment for my child when deemed necessary by qualified medical personnel. This authorization will be in effect until revoked in writing by me.

**SIGNATURE OF PARENT/GUARDIAN:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practice:**

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**Name of Patient:** \_\_\_\_\_

**If not signed by the patient, please indicate.**

**Relationship:** \_\_\_\_\_

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient

*For Office Use Only in Regard to Privacy Notice:*

- Patient unable to sign or initial because \_\_\_\_\_  
\_\_\_\_\_
- Patient had a medical emergency: an attempt to obtain acknowledgement will be made at the next appointment
- Other \_\_\_\_\_  
\_\_\_\_\_
- Patient Refused to Sign