Apple Valley
FAMILY MEDICINE

1008 S. 38th Ave., Suite 110 ▪ Yakima, WA 98902
V: 509-965-1035 ▪ F: 509-225-2700
MEMORIAL Physicians PLLC

Patient Information

Please use your full name as it appears on your insurance or Medicare Card. No Nicknames

Last Name_____ First Name_____ MI_____

Address_____ City/State/Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Physician_____ Birth Date_____ Sex: M F Married Single Other

Soc. Sec.# _____ Employer _____

Spouse's Name_____ Emergency Contact_____

Emergency Phone_____

Guarantor (Responsible for Account)

Last Name_____ First Name_____ MI _____

Address_____ City/State/Zip_____

Home Phone_____ Work Phone_____ Birth Date_____

Sex M F Married Single Other **Soc. Sec.#** _____

❑ **Patient has no insurance, is private pay.**

Patient's Signature (Or Legal Guardian): _____ **Date:** _____

Insurance Information (COPY CARD(s) FRONT & BACK)

Primary Insurance Company _____ Subscriber ID_____

Group ID_____ Relationship to Patient_____ Effective Date_____

Policy Holder's Last Name_____ First_____ MI _____

Sex: M F Birth Date _____ Home Phone_____ Work Phone _____

Employer_____ Co Pay $_____ Referral Needed? Y N

Secondary Insurance Company_____ Subscriber ID_____

Group ID_____ Relationship to Patient_____ Effective Date_____

Policy Holder's Last Name_____ First _____MI_____

Sex: M F Birth Date _____Home Phone_____ Work Phone_____

Employer_____ Co Pay $_____ Referral Needed? Y N

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I authorize my insurance benefits (including Medicare) to be paid directly to Memorial Practice Management for services rendered. I also authorize Memorial Practice Management on behalf of *Apple Valley Family Medicine* to release any information requested by the insurance company with regard to payment of benefits.

I _____ the parent /legal guardian of _____ authorize & consent to routine & emergency medical services to be performed for my child when deemed necessary by qualified medical personnel. This authorization will be in effect until revoked in writing by me.

❑ **I authorize Memorial Practice Management or any collection agencies used by Memorial Practice Management to contact me by my cellular telephone for billing activities or payment arrangements.**

_____ _____

Patient's Signature (Or Legal Guardian) Date Patient's Signature (Or Legal Guardian) Date

_____ _____

Patient's Signature (Or Legal Guardian) Date Patient's Signature (Or Legal Guardian) Date