

Yale UNIVERSITY HEALTH SERVICES

Patient Registration

Last Name		First Name	Middle Initial	Have you ever been a YHP member? <input type="checkbox"/> Yes <input type="checkbox"/> No
Home Address (street, city, state, zip code)				
Social Security Number	Birthdate ____/____/____ Month / Day / Year		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	If so, under what name and social security number? _____ When did your membership terminate? _____
Phone Number Day: _____ Evening: _____ Cell: _____				

What is your affiliation with Yale University?

- | | |
|--|---|
| <input type="checkbox"/> Visitor to Yale | <input type="checkbox"/> Visiting Fellow |
| How long will you be on campus? _____ | <input type="checkbox"/> Special Student—School _____ |
| Reason on campus: _____ | <input type="checkbox"/> Yale Student on leave of absence |
| <input type="checkbox"/> Howard Highes Foundation Employee | <input type="checkbox"/> Visiting Scholar-length of appointment _____ |
| <input type="checkbox"/> University Employee– Non-Member (Employee Health) | <input type="checkbox"/> Yale Student spouse/dependent |
| <input type="checkbox"/> Other _____ | |

Insurance Information (optional)

Name of carrier _____ Address _____
Policy Number _____ Company through which coverage obtained _____

Services available to fee-for-service patients :

Internal Medicine	Laboratory	Optometry	Gynecology	Ophthalmology	Pediatrics
Preventive Medicine	Pharmacy	Radiology	Student Medicine	Travel Clinic	Urgent Care

Payment for Services

Payment is expected in full by cash, check, MasterCard, or Visa. Under certain circumstances, you may request that we bill your insurance carrier for services, or you can request reimbursement for services received at Yale University Health Services (YUHS) through your insurance carrier. YUHS does not assume any responsibility for obtaining reimbursement directly from an insurance carrier for services rendered to patients who are not Yale Health Plan members.

Failure to remit payment for medical treatment will disqualify you for continued services at Yale University Health Services. Fee-for-service participation terminates when you are no longer affiliated with the University.

Acknowledgement of Receipt

As part of compliance with HIPAA, we are required to give you a Notice of Privacy Practices describing how medical information about you may be used and disclosed and how you can obtain this information. Your signature below acknowledges receipt of this notice as part of the fee-for-service patient registration process.

Signature of Patient _____ Date _____

For YUHS Use Only	Effective Date	Termination Date	Entered By	Date	Distributed:
					<input type="checkbox"/> Member Services <input type="checkbox"/> Patient Billing <input type="checkbox"/> _____