York Hospital Patient Registration

Pediatric Associates of York Hospital

York Location	Wells Location	South Berwick Location
16 Hospital Dr Ste D.	112 Sanford Rd.	57 Portland St., Ste 1
York, ME 03909	Wells, ME 04090	So. Berwick, ME 03908
Phone: (207) 351-1710	Phone: (207) 641-6555	Phone: (207) 384-7231
Fax: (207) 351-1708	Fax: (207) 641-6556	Fax: (207) 384-7293

Patient Name_______________________________ **DOB**:________________ Gender: M / F
Street/Mailing ______________________________City __________________State _______ Zip_______

Home Phone (____) - ______ - ______
*__Race__: _________________________ (Alaskan /Indian, Asian, Black, White, Pacific Islander, other)
*__Ethnicity__: _______________________ (Hispanic/ Non Hispanic)
*__Primary Language__: _______________________

Mothers Name: _______________________________________ADDRESS SAME AS PATIENT ☐ **Y** ☐ **N**
Street/Mailing ______________________________City __________________State _______ Zip_______

Home Phone (____) - ______ - ______ Work (____) - ______ - ______ Cell (____) - ______ - ______

Mothers SSN_______ - ____ - _______ DOB: _______/_______/________

Fathers Name: _______________________________________ ADDRESS SAME AS PATIENT ☐ **Y** ☐ **N**

Street/Mailing ______________________________City __________________State _______ Zip_______

Home Phone (____) - ______ - ______ Work (____) - ______ - ______ Cell (____) - ______ - ______

Fathers SSN_______ - ____ - _______ DOB: _______/_______/________

Emergency Contact (someone not in household):

Name: _____________________________________ Relationship to Patient: _____________________

Address: ____ Phone: (_____) - ______ - _____

Pharmacy:________________________ **Address:**_______________________________**Phone:**______________

Insurance Information

Primary:_______________________
Policy #________________Group#________
Policy Owner:_____________________
Date of Birth:_____________________

Secondary:___________________________
Policy # ___________________ Group__________
Policy Owner:_____________________
Date of Birth:_____________________

INSURANCE AND HIPAA AUTHORIZATIONS

- I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, and other health plans to: Pediatric Associates of York Hospital.
- I authorize the release of any medical information necessary to process my insurance claim(s).
- I agree that this authorization will cover all services rendered until such authorization is revoked by me.
- I agree that a photocopy of this form may be used in lieu of the original.
- *I have read and agree with the HIPAA policy provided by York Hospital.*

Patient/Parent Signature______________________________________**Date**____________

STATEMENT OF FINANCIAL RESPONSIBILITY

I accept financial responsibility for the charges incurred at Pediatric Associates of York Hospital. I accept financial responsibility for any charges that may not be covered by my insurance, including deductible, co-payment, balance of the usual and customary fee and collection fees if necessary
Patient/Parent Signature ____**Date**:____________

It is our policy to render the highest quality of health care to all patients without regard to age, race, color, religion, sex, marital status, or national origin and to provide accommodations for patients with disabilities.