Thomas Youm, MD

RYC Orthopaedics, PC

1056 Fifth Avenue, New York, NY 10028

# PATIENT REGISTRATION

Name(last,first)_____ Phone(H)_____

Address_____ Phone(W)_____

City/State/Zip_____ Phone(C)_____

Date of Birth_____ SS#_____

Emergency Contact_____

Relationship_____

Address_____ Phone_____

Referring MD_____ Phone_____

Address_____ _____

Policyholder's Name_____ Relationship_____

Policyholder's Address_____

Phone_____DOB_____SS#_____

Policyholder's Employer_____

Address_____ Phone_____

NAME OF LAW FIRM (No-Fault, Compensation & Liens only)

Attorney Name_____ Phone_____

Address_____

## AUTHORIZATION

A. I authorize Dr. Youm to furnish information to insurance carriers, referring physicians or other health care providers concerning this illness. B. I irrevocably assign to Dr. Youm all payments for medical services rendered and all major medical benefits. C. I will be held responsible for any costs which are not covered by my insurance carrier, and I will be directly billed for such costs.

Signature_____ Date_____