Your Good Health Medical Group, P.A.
Dr. David L. Vastola, D.O.
Internal Medicine and Gastroenterology

PATIENT REGISTRATION INFORMATION
(PLEASE Print Legibly-All information is Strictly Confidential)

Date_____ Name_____
(Last Name) (First Name) (Middle Initial)

Address_____City_____ State_____ Zip_____

Phone_____ Cell Phone_____ Work_____

Sex ☐M ☐F Age_____ Birth date_____ ☐Married ☐Single ☐Divorced ☐Widow

Social Security_____ Employer_____ Occupation_____

Insurance Co (Primary) _____ PO Box_____ ID #_____ Group #_____

Guarantee's Name_____ D.O.B._____ Social Security_____

Insurance Co (Secondary) _____ PO Box_____ ID #_____ Group #_____

Guarantee's Name_____ D.O.B._____ Social Security_____

Person Responsible for Account_____ Relation to Patient_____ Phone #_____

Emergency Contact_____ Phone_____

Pharmacy Name_____ Phone_____

How did you hear about us? ☐Insurance ☐Phone Book ☐Newspaper ☐Other

☐Friend/Family_____ ☐Doctor_____

ASSIGNMENT AND RELEASE

I hereby authorize the payment of benefits of my insurance policy, if any, to be paid directly to Your Good Health Medical Group, P.A. for the services rendered by any of its employees. I further authorize the release of any medical information required by my insurance company. I understand that I am financially responsible for changes not paid by my insurance company. I also agree to be responsible for any charges incurred in the collection of this account, should I default from payment. Such charges include, but are not limited to, legal fees, collection fees or late charges. Also understand and agree to pay the annual administration fee as long as I am a patient of this medical practice.

PATIENT SIGNATURE_____ DATE _____
(Signature of Patient, Parent, Guardian or Personal Representative)