

Connecticut Coastal OB/GYN

Community OB/GYN Group partnered with **Yale** Medicine

<https://www.yalemedicine.org/>

Fax Form to Yale Medicine: 475-246-9946

Rev. 05.2026

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Primary Care Physician: _____
 (Name) (City) (State)

Referring Physician: _____
 (Name) (City) (State)

Information about the patient (Please complete the entire section):

Name: _____
 (Last) (First) (Middle) (Maiden)

Address: _____
 (Number and Street) (City) (State) (Zip)

Phones: Home: _____ Preferred Contact #: _____
 Cell: _____
 Work: _____

Date of Birth: _____ **Email (for MyChart):** _____

Marital Status: Single Married Divorced Widowed Separated Life Partner

Spouse/ Life Partner name: _____

Emergency Contact: _____
 (Name) (Relation to Patient) (Phone)

Ethnicity: Hispanic or Latino or Spanish Origin Not Hispanic or Latino or Spanish Origin

Race: American Indian/ Alaskan Native Asian Black/ African American White/ Caucasian
 Native Hawaiian/ Other Pacific Islander Other _____

Preferred Language: _____ **Requires Interpreter:** _____

Employment Status: Full Time Part Time Retired Disabled Active Military Self Employed
 Student Full Time Student Part Time Other Not Employed

Patient's Employer: _____ **Occupation:** _____

Employer's Address: _____

PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATIONS
I GIVE PERMISSION FOR YOU TO CONTACT OR SPEAK TO THE FOLLOWING PERSON(S) REGARDING ANY AND ALL HEALTH CONDITIONS :

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

GUARANTOR (Person responsible for the bill if not patient):

Name: _____ **Date of Birth:** _____

Address: _____

Relationship to patient: _____ **Phone number:** _____

Guarantor Employer & address: _____

Patient Signature _____ **Date:** _____

Please Complete All Applicable Sections for your Insurance

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| <p>1- Primary Insurance Information</p> <p>Insurance Name: _____</p> <p>Plan name/ Contract type: _____</p> <p>Ins. Address from card: _____</p> <p>City, State, Zip: _____</p> <p>Ins. Phone #: _____</p> <p>Policy/Member ID#: _____</p> <p>Group # (if any): _____</p> <p>Policyholder (if other than patient): _____</p> <p>Subscriber name: _____</p> <p>Subscriber Employer: _____</p> <p>Subscriber Date of Birth: _____ M / F</p> <p>Relation to Patient: _____</p> <p>Effective Date: _____</p> <p>Does this Insurance cover Hospital Services? Y / N</p> | <p>2- Secondary Insurance Information</p> <p>Insurance Name: _____</p> <p>Plan name/ Contract type: _____</p> <p>Ins. Address from card: _____</p> <p>City, State, Zip: _____</p> <p>Ins. Phone #: _____</p> <p>Policy/Member ID#: _____</p> <p>Group # (if any): _____</p> <p>Policyholder (if other than patient): _____</p> <p>Subscriber name: _____</p> <p>Subscriber Employer: _____</p> <p>Subscriber Date of Birth: _____ M / F</p> <p>Relation to Patient: _____</p> <p>Effective Date: _____</p> <p>Does this Insurance cover Hospital Services? Y / N</p> |
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| <p>3- Medicare</p> <p>Medicare ID#: _____</p> <p>Please refer to your Medicare Card. Do you have Hospital Part A? Effective date _____</p> <p>Medical Part B? Effective Date _____</p> <p>Do you have a Managed Medicare plan?</p> <p>Insurance Name _____</p> <p>Member ID # _____</p> | <p>4- Medicaid/ City Welfare</p> <p>State Medicaid ID#: _____</p> <p>Effective date _____</p> <p>Is this a Managed D-SNP HMO plan? Y / N</p> <p>Name of Insurance _____</p> <p>City Welfare Name and ID # _____</p> <p>Effective date _____</p> |
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| <p>5- Is this a Workman's Compensation Claim? Y / N W/C Case Number _____</p> <p>W/C Insurance carrier: _____ Date of Injury: _____</p> <p>Description of Injury: _____</p> <p>Employer at time of injury (if different from current employer): _____</p> <p>Employer Address: _____</p> <p>Phone number: _____</p> <p>Complete section 1 with personal Insurance carrier information.</p> <p>Please provide a contact name and phone number in case there is need for additional information regarding your workman's compensation claim.</p> <p>Contact Name: _____ Phone: _____</p> |
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