



Member Registration Form

This form can also be found online at: AssuranceHealth.org/forms

Please fill out and submit one form per family member. You may leave information blank that remains the same as the main account holder, such as address, emergency contact information, etc.

Member type:

- Main Account Holder (person responsible for billing / other patients associated with this account)
- Spouse of Main Account Holder
- Dependent of Main Account Holder

Name of Main Account Holder (if spouse or dependent): _____

Basic Member Information

First Name _____

Last Name _____

Middle Initial _____ Gender M F

Date of Birth _____

Main Phone _____

Alternate Phone _____

Alternate Phone _____

Email Address _____

Emergency Contact Information

First Name _____

Last Name _____

Phone _____

Relationship to Member _____

Address (including City, State Zip)

How did you hear about Assurance?

(Name of person, radio, facebook, news, etc.)

I wish to begin membership on (date)

Do you have health insurance? Yes No

We currently do not prescribe or manage pain medications. Please list current medications below (list more on back if necessary):

Billing information will be obtained via phone or in person.

Mail or drop off completed forms to:

Assurance Healthcare & Counseling Center
ATTN: Member Registration
1020 S 40th Ave. Suite A
Yakima, WA 98908

Fax completed forms to:

509-823-4652

Email completed forms to:

registrations@assurancehealth.org

Assurance Healthcare & Counseling Center

509-823-4650 | info@assurancehealth.org | AssuranceHealth.org