

PATIENT REGISTRATION

PLEASE PRINT

Name _____
Last First MI Nickname

Address _____ Gender: Male Female
 City _____ State _____ Zip _____ Date of Birth ____ / ____ / ____

Home Phone (_____) _____ Social Security # _____
 Cell Phone (_____) _____ Marital Status: Single Married Widowed
 Employer _____ Name of Spouse _____
 Work Phone (_____) _____ Retired: Yes No

REFERRING PHYSICIAN(S)

Referred By _____
Last First Address / Phone

Primary Care Physician _____
Last First Address / Phone

INSURANCE

PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD AND PAY YOUR APPLICABLE CO-PAYMENT.

Primary Insurance _____	Secondary Insurance _____
Insured _____ DOB _____	Insured _____ DOB _____
Employer _____	Employer _____
Relationship to Patient _____	Relationship to Patient _____
Insured ID # _____	Insured ID # _____
Group # _____	Group # _____

Injury Information

Date of Injury _____ Place _____ Home or School Work Work Claim # _____
 Nature or Cause of Injury _____ Auto Accident Auto Claim # _____

Emergency Information: Person to contact in case of emergency, not living at the above address.

Name _____ Relationship to Patient _____
 Address _____ Phone (_____) _____
 City _____ State _____ Zip _____

Please read the following statement carefully before signing.

I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize the clinic to receive all benefits to which my dependents or I are entitled to under my health insurance plan. I also authorize the healthcare provider or insurance company to release any information required for this claim. In addition, I will not withhold or delay payment if my insurance company denies payment on any of my charges. I have also been informed of the \$40.00 fee (per RCW 62A.3-515 & 520) on checks returned from my bank NSF. The undersigned agrees that whether he/she signs as an agent, that he/she is obligated to pay for the account. Past due balance will be charged 1% interest per month (per RCW 19.52) on the unpaid balance.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Signature _____ Relationship to Patient _____
 Date _____