PATIENT REGISTRATION FORM

PLEASE PRINT

PT. NAME ______________________________ M ____ F ____ Date of Birth ______________
Last First MI
SS# ______________
ADDRESS ______________ MARITAL STATUS ______________
CITY/STATE ______________ ZIP ______ OCCUPATION ______________
CELL PHONE (_____) ______________ EMPLOYER ______________
HOME PHONE (_____) ______________ ADDRESS ______________
SPOUSE'S NAME ______________ WORK PHONE (_____) ______________
SPOUSE'S DATE OF BIRTH ______________ **PRIMARY CARE PHYSICIAN** ______________
REFERRED BY

PRIMARY INSURANCE ______________
Insured ______________ DOB ______
Employer ______________
Relationship to patient ______________
Insured ID No. ______________
Group No. ______________

SECONDARY INSURANCE ______________
Insured ______________ DOB ______
Employer ______________
Relationship to patient ______________
Insured ID No. ______________
Group No. ______________

BILLING: If person responsible for bill is **other than above patient,** please complete.
NAME ______________ SS# ______________
Last First MI
OCCUPATION ______________
Relationship to patient ______________ EMPLOYER ______________
ADDRESS ______________ ADDRESS ______________
CITY/STATE ______________ ZIP ______ CITY/STATE ______________ ZIP ______
CELL PHONE (_____) ______________ WORK PHONE (_____) ______________
HOME PHONE (_____) ______________

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. 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 **$35.00 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. Should the balance of the account exceed an amount the undersigned is able to pay in full, an agreed payment plan can be established with **1% interest per month (per RCW 19.52)** on the unpaid balance.

SIGNATURE ______________ RELATIONSHIP TO PATIENT ______________
DATE ______________