

LAPAROSCOPIC SURGERY NORTHWEST

PATIENT NAME: FIRST _____ M.I. _____ LAST _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

HOME PHONE #: () _____ CELL PHONE #: () _____

DATE OF BIRTH: / / Female Male Other Marital Status: single married divorced widowed

I GIVE PERMISSION TO RECEIVE VOICE MAIL MESSAGES REGARDING MY HEALTH CARE. ()

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

VET/AN/TRIWEST: SOCIAL SECURITY # _____

ON-THE-JOB INJURY? NO ___ YES ___ IF YES, DATE OF INJURY: _____ CLAIM #: _____

CLAIMS MANAGER NAME _____ PHONE () _____

PRIMARY INSURANCE: _____

POLICY HOLDER: (CIRCLE ONE) SELF / SPOUSE / CHILD

POLICY HOLDER INFORMATION, IF OTHER THAN PATIENT:

NAME: _____ DATE OF BIRTH: _____

SECONDARY INSURANCE: _____

POLICY HOLDER: (CIRCLE ONE) SELF / SPOUSE / OTHER

POLICY HOLDER INFORMATION, IF OTHER THAN PATIENT:

NAME: _____ DATE OF BIRTH: _____

OTHER INFORMATION:

EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____ WORK PHONE #: _____

FAMILY PRACTICE DOCTOR: _____ PHONE: _____

EMERGENCY CONTACT: _____ PH #: _____ RELATIONSHIP _____

COMPLETE INFORMATION BELOW IF PATIENT IS A MINOR/GAURDIANSHIP

PARENT/GAURDIAN NAME: _____ PHONE: _____

NOTICE: WE KEEP A RECORD OF THE HEALTH CARE SERVICES WE PROVIDE FOR YOU. YOU MAY ASK TO SEE AND COPY THAT RECORD. YOU MAY ALSO ASK TO CORRECT THAT RECORD. WE WILL NOT DISCLOSE YOUR RECORD TO OTHERS UNLESS YOU DIRECT US TO DO SO OR UNLESS THE LAW AUTHORIZES OR COMPELS US TO DO SO. IT IS THE POLICY OF THIS OFFICE THAT OUR CONTRACT IS WITH YOU, THE PATIENT OR RESPONSIBLE PARTY AND NOT WITH YOUR INSURANCE COMPANY. RESPONSIBILITY FOR PAYMENT REMAINS WITH YOU AT ALL TIMES, EVEN THOUGH YOU MAY HAVE AN INSURANCE CLAIM OR LEGAL SUIT PENDING.

I AUTHORIZE MY INSURANCE COMPANY TO MAKE PAYMENT DIRECTLY TO LSNW FOR PROFESSIONAL SERVICES RENDERED. I AUTHORIZE LSNW TO RELEASE ANY INFORMATION REQUESTED BY MY INSURANCE COMPANY, EMPLOYER OR OTHER PHYSICIANS.

SIGNATURE (PATIENT/GUARDIAN): _____ DATE: _____