Office Use Only

Patient Note(s): _____

_____

PATIENT REGISTRATION

(Please Print)

LAST NAME: _____ **FIRST:** _____ **MI:** _____ **SSN#:** _____

Gender: Male Female **Date of Birth:** Month: _____ Day: _____ Year: _____

Is this your legal name? Yes No	**If not, what is your legal name?**	**(Former or alternate name):**

Mailing Address/Apt#:	**City:**	**State:**	**Zip:**
Home Address (if different than mailing address)**:**	**City:**	**State:**	**Zip:**

Home #:	**Work #** (& Extension)**:**	**Mobile #:**	**E-Mail Address:**
Preferred #: Home Work Mobile			

Need Interpreter? Yes No **Spoken Language:** _____ **Written Language:** _____	**Marital Status?** Yes No Widowed Separated Divorced Reg Domestic Partner Life Partner	**Religion** (optional):

Racial Designation/Ethnicity: **OPTIONAL** information for Federal statistics program administration reporting, and civil rights compliance reporting only. Please mark one or more:

ALASKAN NATIVE	NATIVE AMERICAN	ASIAN	AFRICAN AMERICAN or BLACK
CAUSIAN or WHITE	HISPANIC or LATINO	NATIVE HAWAIIAN	PACIFIC ISLANDER
MIXED RACE	OTHER		

How did you hear about us? Mark one**:**	Friend/Family Member	Physician	Physician Referral Line
	Newspaper/Magazine	Internet	Radio TV
	Attorney	Special Event	Other: _____

Driver's License No:	**Employment Status** (Age 18 & Over) Mark one**:** Full Time Part Time Not Employed Self-Employed Active Military Duty Student Status: Full Time Part Time

Employer:	**Occupation:**	**Date Started:**	**Employer #:**
Referring Physician:	**Physician Address:**		**Physician #:**
Primary Physician:	**Physician Address:**		**Physician #:**

IN CASE OF EMERGENCY CONTACT

Name of local friend or relative (not living at same address):	**Relationship to patient:**	**Home #:**	**Work #:**	**Mobile #:**
		Preferred #: Home Work Mobile		
Address:		**City:**	**State:**	**Zip:**

LEGAL GUARDIAN

(if different from Responsible Party Below)

LAST NAME: _____ **FIRST:** _____ **MI:** _____ **Birth Date**: _____

RESPONSIBLE PARTY INFORMATION

(Person Responsible for Payment of Account if Patient is under age 18)

LAST NAME: _____ **FIRST:** _____ **MI:** _____ **SSN#**: _____

Gender: Male Female **Date of Birth:** Month: _____ Day: _____ Year: _____

Mailing/Billing Address/Apt#:	**City:**	**State:**	**Zip:**
Responsible Party's Relationship to Patient: Spouse Parent Other: _____		**Is this person a patient here?** Yes No	

Home #:	**Work #**:	**Mobile #**:	**Employment Status** (Mark one)**:**
			Full Time Part Time Not Employed Self-Employed
Preferred #:	Home Work Mobile		Active Military Duty Student Status: Full Time Part Time

Employer Name:	**Employer Address:**	**Employer #:**

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

PRIMARY INSURANCE – Subscriber Information

Is this patient covered by insurance? Yes No (If No, please refer to Financial Policy)

Subscriber's Information:

LAST NAME: _____ **FIRST:** _____ **MI:** _____ **SSN#**: _____

Gender: Male Female **Date of Birth:** Month: _____ Day: _____ Year: _____

Subscriber's Address (if different from patient's)**:**	**City:**	**State:**	**Zip:**

Home #:	**Work #**:	**Mobile #:**	**Employment Status** (Mark one)**:**
			Full Time Part Time Not Employed Self-Employed

Preferred #: Home Work Mobile	Active Military Duty Student Status: Full Time Part Time	
Subscriber's Employer Name:	**Employer Address:**	**Employer #:**

Please indicate Primary Insurance Company:	REGENCE PREMERA AETNA CIGNA UHC MEDICARE KAISER FIRSTCHOICE Labor & Industries Other: _____

Insurance Claims-to Address:	**City:**	**State:**	**Zip:**

Patient's relationship to Subscriber: Self Spouse Child Other	**Group #:**	**Policy/Subscriber ID #:**	**Subscriber Group Name:**
(Patient's) Member ID (if different from subscriber's):		**Ins Effective Date:**	**Co-Payment $:**

SECONDARY INSURANCE – Subscriber Information

Is this patient covered by insurance? Yes No (If No, please refer to Financial Policy)

Subscriber's Information:

LAST NAME: _____ **FIRST:** _____ **MI:** _____ **SSN#:** _____

Gender: Male Female **Date of Birth:** Month: _____ Day: _____ Year: _____

Subscriber's Address (if different from patient's)**:**	**City:**	**State:**	**Zip:**

Home #	**Work #**	**Mobile #**	**Employment Status** (Mark one)**:**
			Full Time Part Time Not Employed Self-Employed Active Military Duty Student Status: Full Time Part Time
Preferred #: Home Work Mobile			

Subscriber's Employer Name:	**Employer Address:**	**Employer #:**

Please indicate Primary Insurance Company:	REGENCE PREMERA AETNA CIGNA UHC MEDICARE KAISER FIRSTCHOICE Labor & Industries Other: _____

Insurance Claims-to Address:	**City:**	**State:**	**Zip:**

Patient's relationship to Subscriber: Self Spouse Child Other	**Group #:**	**Policy/Subscriber ID #:**	**Subscriber Group Name:**
(Patient's) Member ID (if different from subscriber's):		**Ins Effective Date:**	**Co-Payment $:**