Office	Use	Only
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Patient Note(s):		
.,	_	

PATIENT REGISTRATION (Please Print)							
LAST NAME:		FIRST:		MI:	S	SN#:	
Gender: Male Fema							Year:
Is this your legal name?	If not, what i	is your legal nan	ne?	(Former	or alterna	te name):	
Yes No							
Mailing Address/Apt#:			City:			State:	Zip:
Home Address (if different the	nan mailing a	ddress):	City:			State:	Zip:
Home #: Work #	(& Extension	n): Mobile #:		E-Mail A	ddress:		
	Home Wo						
Need Interpreter? Yes	No	Marital St				Religion	(optional):
Spoken Language:		Yes Sanara	No tod		dowed		
Written Language: Separated Divorced Reg Domestic Partner Life Partner							
Racial Designation/Ethnicity: OPTIONAL in	nformation for Federa	al statistics program admi	nistration reporting,	and civil rights	compliance rep	orting only. Plea	ase mark one or more:
ALASKAN NATIVE	NATIVE A	AMERICAN	ASIAN		AFF	RICAN AMI	ERICAN or BLACK
CAUSIAN or WHITE	HISPANI	ANIC or LATINO NATIVE HAWAIIAN PAC			IFIC ISLA	NDER	
MIXED RACE	OTHER						
How did you hear about us?	Friend/F	d/Family Member Physician		an	Physician Referral Line		
Mark one: News		spaper/Magazine Internet		Radio TV			
Attorney Special Event Other				r:			
Driver's License No:	Eı	mployment Stat	us (Age 18 &	Over) Ma	ark one:		
		Full Time	Part	Time	Not E	Employed	Self-Employed
		Active Military [Outy Stud	ent Statu	s: Full 7	Γime	Part Time
Employer:	О	ccupation:			Date Star	ted:	Employer #:
Referring Physician: Physician Address:							Physician #:
Primary Physician:	Pl	Physician Address:				Physician #:	
	1						<u> </u>

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IN CASE OF EMERGENCY CONTACT								
	t same addres	1	elationship to atient:	Home #:	Work #	! :	Mobile #:	
		·		Preferred #:	Home	Work	Mobile	
Address:				City:		State:	Zip:	
			LEGAL GU (if different from Respo					
LAST NAMI	E:		FIRST:	MI:		Birth Date	:	
			Sponsible for Payment of A			8)		
LAST NAMI	E:		FIRST:	MI: _	s	SN#:		
Gender:	Male Fe	emale	Date of Birth:	Month:	_ Day: _		Year:	
Mailing/Bill	ing Address/	Apt#:		City:		State:	Zip:	
Responsible Party's Relationship to Patient: Spouse Parent Other: Yes No						atient here?		
Home #:	Work #:	Mobile #:	Employment Status	(Mark one):				
			Full Time Part Time Not Employed Self-E					
Preferred #:	Home Wo	Work Mobile Active Military Duty Student Status: Full Time Part Time						
Employer N	ame:		Employer Add	dress:			Employer #:	
			INSURANCE IN	FORMATION	J			
		(Ple	ase give your insurance	card to the receptio	nist)			
	PRI	MARY	INSURANCE –	Subscriber In	form	ation		
Is this patie	ent covered b	y insurance	? Yes No (If No	, please refer to Fina	ncial Poli	cy)		
Subscriber's Information:								
LAST NAME: FIRST: MI: SSN#:								
Gender: Male Female Date of Birth: Month: Day: Year:								
Subscriber's	s Address (if d	lifferent fror	n patient's):	City:		State:	Zip:	
Home #:	Work #:	Mobile #:	Employment Status	(Mark one):				
			Full Time	Part Time	Not E	Employed	Self-Employed	
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This documen			that is proprietary to CORE Injur duced in whole or in part, witho					

Preferred #:	referred #: Home Work Mobile Active Military Duty Student Status: Full Time						Part Time		
Subscriber's Employer Name: Employer Address:						ss:			Employer #:
Please indic	ate Primary	REGENO	E P	REMERA	ΑE	TNA	CIGNA		UHC
Insurance C	ompany:	MEDICA	RE K	AISER	FIR	STCHOICE	Labor & Ind	dustries	Other:
Insurance C	laims-to Ado	dress:			(City:		State:	Zip:
	_	o Subscriber:		Group #:		Policy/Subscr	iber ID #:	Subscril	er Group Name:
Self	Spouse	Child Ot	her						
(Patient's) N	Member ID (if different fror	n subscr	iber's):		Ins Effective I	Date:	Co-Payr	ment \$:
	SEC	ONDARY	INSU	IRANCE	– S	Subscriber	^r Inforn	natior	1
Is this patie	ent covered	by insurance?	Ye	s No (If N	lo, ple	ease refer to Fin	ancial Polic	cy)	
Subscriber	's Information	on:							
LAST NAMI	= :		FII	RST:		MI:	ss	SN#:	
Gender: Male Female Date of Birth: Mo				Moi	onth: Day: Year:			Year:	
Subscriber's	Address (if	different from	patient'	s):		City:		State:	Zip:
Home #	Work #	Mobile #	Fmmla	umant Ctatu	a / N / a	ark ono).			
nome #	WOLK #	Wiobile #	Emplo	yment Statu	S (IVI	ark one):			
			Full	Time		Part Time	Not E	mployed	Self-Employed
Preferred #:	Home W	/ork Mobile	Acti	ve Military D	uty	Student Status	s: Full Ti	ime	Part Time
Subscriber's	Employer N	lame:		Employer A	ddres	ss:			Employer #:
Please indicate Primary REGENCE PREMERA AETNA CIGNA U						UHC			
			KAISER FIRSTCHOICE Labor & Indus		dustries	Other:			
Insurance C	laims-to Add	dress:			City	:		State:	Zip:
Patient's relationship to Subscriber: Self Spouse Child Other Group #				Group #:		Policy/Subscri	ber ID #:	Subscril	per Group Name:
(Patient's) Member ID (if different from subscribe				iber's):		Ins Effective Date: Co-Payment \$:		nent \$:	

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Г	This design and section and identical information that is according to CORT being Management Maitheath and according to the information contained the coin					