

PATIENT REGISTRATION

Please Print and Answer all Questions

PATIENT INFORMATION

PATIENT'S NAME	LAST	FIRST	M.I.	TODAY'S DATE
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SOCIAL SECURITY NUMBER	REFERRING PHYSICIAN
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GENDER: <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	BIRTHDATE	AGE	HOME PHONE	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED
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MAILING ADDRESS: STREET	CITY	STATE	ZIP
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PATIENT'S EMPLOYER	OCCUPATION	WORK PHONE
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EMPLOYER ADDRESS

NAME OF SPOUSE	SPOUSE'S BIRTHDATE	SPOUSE'S EMPLOYER	SPOUSE'S SOCIAL SECURITY #
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EMPLOYER ADDRESS	WORK PHONE
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EMERGENCY CONTACT:	PHONE
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PERSON RESPONSIBLE FOR BILL, IF NOT PATIENT:	<input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER
NAME	MAILING ADDRESS

EMPLOYER

INSURANCE INFORMATION

<input type="checkbox"/> Aetna U.S. Healthcare	<input type="checkbox"/> Health Plus	<input type="checkbox"/> Northstar Administrators	<input type="checkbox"/> Regence Blue Shield	<input type="checkbox"/> Virginia Mason Health Plan
<input type="checkbox"/> Basic Health Plan	<input type="checkbox"/> Labor & Industries/ Self-Insured Industrial Claim	<input type="checkbox"/> One Health Plan	<input type="checkbox"/> Regence Care	<input type="checkbox"/> Not Covered By Insurance
<input type="checkbox"/> Cigna	<input type="checkbox"/> Lifewise	<input type="checkbox"/> Pacificare of WA	<input type="checkbox"/> Retail Clerk	<input type="checkbox"/> Other, List Below
<input type="checkbox"/> DSHS/Welfare Dept. Coupon	<input type="checkbox"/> Medicare	<input type="checkbox"/> Pac Med	<input type="checkbox"/> TriCare	
<input type="checkbox"/> First Choice	<input type="checkbox"/> MultiPlan Inc.	<input type="checkbox"/> Premera Blue Cross	<input type="checkbox"/> Uniform Medical Plan	
<input type="checkbox"/> First Health Network		<input type="checkbox"/> PHCS	<input type="checkbox"/> United Healthcare	

PRIMARY INSURANCE CO.	SUBSCRIBER NAME
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GROUP NUMBER	ID NUMBER
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SECONDARY INSURANCE CO.	SUBSCRIBER NAME
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GROUP NUMBER	ID NUMBER
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IF WORK RELATED INJURY:	CLAIM #	DATE OF INJURY
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EMPLOYER AT TIME OF INJURY	BODY PART INJURED
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I give authorization to the Doctor or Insurance Company to release information required to process this claim. I hereby authorize that my insurance benefits be paid directly to the physician. I am financially responsible for any balance due. If my account is turned over for collection, I agree to assume responsibility for all collection costs. I have received a copy of the Billing & Payment Policies sheet.

Signature _____ Date _____