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New Patient Registration Form

Today's date:			Primary Care Provider:			
PATIENT INFORMATION						
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Widow	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:			Home phone no.: ( )			
P.O. box:	City:	State:	ZIP Code:			
Occupation:	Employer:	Employer phone no.: ( )				
Were you referred to our office? ❑ Yes ❑ No If yes, by whom?						
(Mark all that apply): You may leave voice mail appointment reminders at: ❑ Home ❑ Work ❑ Cell ❑ Text						
(Mark all that apply): You may send general information and appointment reminders by: ❑ e-Mail ❑ Text						
You may share general information with the following person: Name:_____ Relationship: _____ ❑ Yes ❑ No						
INSURANCE INFORMATION (IF APPLICABLE)						
(Please provide a copy of your insurance card, front and back, and photo identification.)						
Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )			
Is this person a patient here? ❑ Yes ❑ No						
Occupation:	Employer:	Employer address:	Employer phone no.:			
Is this patient covered by insurance? ❑ Yes ❑ No	Other Programs (Such as L&I)					
Please indicate primary insurance ❑ Regence ❑ Premera ❑ Group Health ❑ Medicare ❑ Aetna ❑ United Healthcare ❑ Value Options ❑ Cigna ❑ Blue Cross Blue Shield ❑ Other						
Subscriber's name:		Birth date: / /	Policy no.: (including prefix & suffix)			
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other						
Name of secondary insurance (if applicable):	Subscriber's name:	Policy no.: (including prefix & suffix)				
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other						
Is patient's condition related to: Employment? ❑ Yes ❑ No Auto Accident? ❑ Yes ❑ No Other Accident? ❑ Yes ❑ No						
IN CASE OF EMERGENCY						
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )			

1. I understand that I am responsible for charges not covered or reimbursed by my health plan or similar payer. I agree to pay you directly if my insurer, health plan, employer program or similar benefit program does not pay.
2. I authorize my insurer, health plan employer program or similar benefit program to release information to you regarding my coverage.
3. My right to payment for care, treatment, supplies and other services are hereby assigned to you. This assignment covers any and all benefits under Medicare, other government sponsored programs, insurance, employer programs and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. If my insurer, health plan, employer program or similar benefit program does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to you.
4. I understand and authorize release of all health information about me to my insurer, health plan, employer program or similar benefit program identified above to obtain payment for care, treatment, supplies and other services. The above information is true to the best of my knowledge.

Patient/Guardian signature *Date*