

_____ **NEW** _____ **UPDATE**

PATIENT LAST NAME		FIRST NAME (legal)		MI	PREFERRED OR NICKNAME	
DATE OF BIRTH	SEX M F	RACE		SOCIAL SECURITY #		
STREET ADDRESS			APT #	CITY	STATE	ZIP CODE 4 DIGIT
MAILING ADDRESS (if different)			APT #	CITY	STATE	ZIP CODE 5 DIGIT
HOME PHONE ()		WORK PHONE ()		EXT	CELL PHONE ()	
REFERRING DOCTOR				MARITAL STATUS MARRIED _____ DIVORCED _____ OTHER _____ SINGLE _____ WIDOWED _____ SEPARATED _____		
PRIMARY CARE DOCTOR				LANGUAGE		

PATIENT EMPLOYER

EMPLOYER NAME			OCCUPATION			
STREET ADDRESS			CITY	STATE	ZIP CODE 4 DIGIT	

PRIMARY INSURANCE

INSURANCE COMPANY NAME		RELATION TO SUBSCRIBER			COPAY
SUBSCRIBER'S NAME		SUBSCRIBERS EMPLOYER		SUBSCRIBER'S SOCIAL SECURITY #	
SUBSCRIBERS DATE OF BIRTH	SUBSCRIBER'S SEX MALE _____ FEMALE _____	SUBSCRIBERS ID #		GROUP NUMBER	

SECONDARY INSURANCE

INSURANCE COMPANY NAME		RELATION TO SUBSCRIBER			COPAY
SUBSCRIBER'S NAME		SUBSCRIBERS EMPLOYER		SUBSCRIBER'S SOCIAL SECURITY #	
SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBERS SEX MALE _____ FEMALE _____	SUBSCRIBERS ID #		GROUP NUMBER	

EMERGENCY CONTACT (NOT LIVING WITH YOU)	NAME	RELATIONSHIP	PHONE NUMBER ()
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RESPONSIBLE PARTY

WHO IS RESPONSIBLE FOR THE REMAINING BALANCE ON THIS ACCOUNT?

_____ SELF						
_____ SPOUSE	SOCIAL SECURITY #		LAST NAME	FIRST NAME	MI	
	STREET ADDRESS			CITY	STATE	ZIP CODE 4 DIGIT
_____ PARENT	HOME PHONE ()		WORK OR CELL PHONE ()		EXT	DATE OF BIRTH
	DATE OF BIRTH		SEX M F			
_____ GUARDIAN	WORKERS COMP CLAIM #		DATE OF INJURY	EMPLOYER	STATE OR SELF INSURED? YES NO	

I, the patient or guardian, certify that the information contained on this form is true to the best of my knowledge. I accept responsibility for the charges incurred by the patient, and agree to pay all bills at the time of service, unless prior arrangements have been made. I authorize the physician and clinic to release any information to process insurance claims. I authorize my insurance claim to be paid directly to the clinic.

I authorize **Western Washington Medical Group** to leave messages, which may contain details of my medical condition on my voicemail box

if they are unable to reach me.

PATIENT SIGNATURE	VOICEMAIL #	DATE	INITIALS
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For office use only Dr. _____	Ins. code	Acct #	Initials
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