

**WESTERN WASHINGTON MEDICAL GROUP
DEPARTMENT OF ENDOCRINOLOGY**

REGISTRATION FORM

_____ **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
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			
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 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	SEX M F
_____ GUARDIAN	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.

VOICEMAIL # _____

INITIALS _____

PATIENT SIGNATURE _____

DATE _____

<i>For office use only</i>			
Dr. _____	Ins. code _____	Acct # _____	Initials _____