

**WESTERN WASHINGTON MEDICAL GROUP
DEPARTMENT OF GENERAL SURGERY**

REGISTRATION FORM

ACCOUNT# _____ 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 (IF NOT EMPLOYED ARE YOU RETIRED OR DISABLED)

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- HOME/WORK/CELL ()
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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	WORKERS COMP CLAIM #	DATE OF INJURY	EMPLOYER	STATE OR SELF INSURED?

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 _____