

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 _____		
PRIMARY CARE DOCTOR				SINGLE _____ WIDOWED _____ SEPARATED _____		
PHARMACY NAME, PHONE NUMBER AND LOCATION				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 ()	

RESPONSIBLE PARTY

WHO IS RESPONSIBLE FOR THE REMAINING BALANCE ON THIS ACCOUNT?

____ SELF						
____ SPOUSE						
SOCIAL SECURITY #		LAST NAME		FIRST NAME		MI
____ PARENT			STREET ADDRESS		CITY	STATE ZIP CODE 4 DIGIT
____ GUARDIAN			HOME PHONE ()		WORK OR CELL PHONE EXT ()	
DATE OF BIRTH		SEX M F				
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 _____