WESTERN WASHINGTON MEDICAL GROUP
DEPARTMENT OF RHEUMATOLOGY

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 ( )

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? 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***

For office use only
Dr._____________________ **Ins. code**_________________________ **Acct #** ____________________________ **Initials** ________