

**WESTERN WASHINGTON MEDICAL GROUP  
DEPARTMENT OF UROLOGY**

**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
	DATE OF INJURY		EMPLOYER		STATE OR SELF INSURED? YES NO	
_____ GUARDIAN	HOME PHONE ( )		WORK OR CELL PHONE ( )		EXT	DATE OF BIRTH
						SEX M F

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 \_\_\_\_\_