WESTERN WASHINGTON MEDICAL GROUP ***REGISTRATION FORM***
DEPARTMENT OF NEPHROLOGY

ACCOUNT#_____ NEW ____ UPDATE ____

PATIENT LAST NAME	FIRST NAME (legal)	MI	PREFERRED OR NICKNAME

DATE OF BIRTH	SEX M F	RACE ETHNICITY	SOCIAL SECURITY # PREFERRED LANGUAGE

MAILING ADDRESS	APT #	CITY	STATE	ZIP CODE 4 DIGIT

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	PREFERRED EMAIL ADDRESS

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 (* If self do not fill in right field.) ____ SPOUSE ____ PARENT ____ GUARDIAN	SOCIAL SECURITY #	LAST NAME	FIRST NAME	MI
	STREET ADDRESS	CITY	STATE	ZIP CODE 4 DIGIT
	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.

INITIALS VOICEMAIL #

PATIENT SIGNATURE _____ ***DATE***

For office use only
Dr._____ Ins. code_____ Acct #_____ Initials____