

**WESTERN WASHINGTON MEDICAL GROUP
DEPARTMENT OF PULMONARY AND SLEEP MEDICINE**

REGISTRATION FORM

ACCOUNT# _____ NEW _____ UPDATE _____

PATIENT LAST NAME		FIRST NAME (legal)		MI	PREFERRED OR NICKNAME	
DATE OF BIRTH	SEX M F	RACE	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.)	SOCIAL SECURITY #		LAST NAME		FIRST NAME	
____ SPOUSE	STREET ADDRESS		CITY	STATE	ZIP CODE 4 DIGIT	
____ PARENT	HOME PHONE ()		WORK OR CELL PHONE ()		EXT	DATE OF BIRTH
____ GUARDIAN						SEX M F
WORKERS COMP CLAIM #	DATE OF INJURY	EMPLOYER			STATE OR SELF INSURED?	
<p>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.</p>						
PATIENT SIGNATURE			INITIALS		VOICEMAIL #	
					DATE	
<p>For office use only Dr. _____ Ins. code _____ Acct # _____ initials _____</p>						