Western Washington Medical Group
Imaging Center

Patient Registration Form

Account #_____ NEW___ Update___

PATIENT LAST NAME		FIRST NAME (LEGAL)	MI	PREFERRED OR NICKNAME
DATE OF BIRTH	GENDER M F	RACE ETHNICITY		PREFERED LANGUAGE

MAILING ADDRESS	APT	CITY	STATE	ZIP CODE
STREET ADDRESS	APT	CITY	STATE	ZIP CODE

HOME PHONE ( )	CELL PHONE ( )	WORK PHONE ( )	EXT

REFERRING DOCTOR	MARITAL STATUS: MARRIED _____ DIVORCED _____ SEPARATED_____ SINGLE _____ WIDOWED _____ OTHER _____
PRIMARY CARE DOCTOR	
PHARMACY NAME LOCATION PHONE NUMBER	PREFERRED EMAIL ADDRESS

PATIENT EMPLOYER (IF NOT EMPLOYED ARE YOU RETIRED _____ OR DISABLED _____)

EMPLOYER NAME	OCCUPATION		
STREET ADDRESS	CITY	STATE	ZIP CODE

PRIMARY INSURANCE

INSURANCE COMPANY NAME	RELATION TO SUBSCRIBER	COPAY
SUBSCRIBER'S NAME	SUBSCRIBER'S EMPLOYER	

SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SEX M F	SUBSCRIBER'S ID #	GROUP NUMBER

SECONDARY INSURANCE

INSURANCE COMPANY NAME	RELATION TO SUBSCRIBER	COPAY
SUBSCRIBER'S NAME	SUBSCRIBER'S EMPLOYER	

SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SEX M F	SUBSCRIBER'S ID #	GROUP NUMBER

RESPONSIBLE PARTY WHO IS RESPONSIBLE FOR REMAINING BALANCE ON THIS ACCOUNT?

_____SELF (*IF SELF DO NOT FILL IN RIGHT FIELD.) _____SPOUSE _____PARENT _____GUARDIAN	LAST NAME	FIRST NAME	MI	
	STREET ADRESS	CITY	STATE	ZIP CODE
	HOME PHONE ( )	WORK OR CELL PHONE ( )	DATE OF BIRTH	GENDER M F

WORKER COPM CLAIM#	DATE OF INJURY	EMPLOYER	STATE OR SELF INJURED?
AUTO INSURANCE COMPANY NAME	DATE OF INJURY	MVA CLAIM #	

EMERGENCY CONTACT (NOT LIVING WITH YOU)

NAME	RELATIONSHIP	PHONE PHONE ( )

The undersigned hereby authorizes the release of any information relating to all claims for my benefits submitted on behalf of myself and dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I hereby authorize my insurance company to pay and hereby assign directly to WWMG IMAGING CENTER & SKAGIT REDIOLOGY, INC all benefits, if any, otherwise payable to me for their services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to WWMG IMAGING CENTER & SKAGIT REDIOLOGY, INC will be credited to my account, in accordance with the above assignment.

PATIENT SIGNATURE _____DATE_____