WESTERN WASHINGTON MEDICAL GROUP ***REGISTRATION FORM***

ACCOUNT#_____ NEW _____ UPDATE _____

PATIENT LAST NAME	FIRST NAME (legal)	MI	PREFERRED OR NICKNAME	DATE OF BIRTH

RACE	ETHNICITY	PREFERRED LANGUAGE	SOCIAL SECURITY #

SEX M ___ F ___
Other: _____
(Please List)

GENDER IDENTITY: __Genderqueer identifies as neither Male or Female
__Identifies as Male __Female-to-male __Additional gender category or other, please specify _____
__Identifies as Male __Male-to-female __Choose not to disclose

SEXUAL ORIENTATION __ Choose not to disclose
__ Heterosexual (straight) __ Bisexual
__ Homosexual (gay/lesbian) __ Other _____

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	PREFERRED EMAIL ADDRESS
( )	( )	( )	

REFERRING DOCTOR

PRIMARY CARE DOCTOR

HOW DID YOU HEAR OF US?
Internet ___ Google Maps ___
Friend/Family ___ Drove by location ___ Insurance Company
___ Mailer/ Marketing ___

MARITAL STATUS
MARRIED _____ DIVORCED _____ OTHER _____
SINGLE _____ WIDOWED _____ SEPARATED _____

PHARMACY NAME, PHONE NUMBER AND LOCATION

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	SUBSCRIBERS ID #	GROUP NUMBER
	MALE ___ FEMALE ___ OTHER ____		

SECONDARY INSURANCE

INSURANCE COMPANY NAME	RELATION TO SUBSCRIBER	COPAY

SUBSCRIBER'S NAME	SUBSCRIBERS EMPLOYER

SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBERS SEX	SUBSCRIBERS ID #	GROUP NUMBER
	MALE ___ FEMALE ___ OTHER ____		

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 __ Other __

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**