WESTERN WASHINGTON MEDICAL GROUP ***REGISTRATION FORM***
DEPARTMENT OF FAMILY MEDICINE

ACCOUNT#_____ NEW _____ UPDATE _____

PATIENT LAST NAME		FIRST NAME (legal)	MI	PREFERRED OR NICKNAME
DATE OF BIRTH	SEX M F	RACE ETHINICITY	SOCIAL SECURITY # Preferred Language	

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 E-mail 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

_____ 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.

VOICEMAIL # _____ INITIALS

PATIENT SIGNATURE _____ ***DATE***

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