WESTERN WASHINGTON MEDICAL GROUP
DEPARTMENT OF CARDIOLOGY

REGISTRATION FORM

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.)	SOCIAL SECURITY #		LAST NAME		FIRST NAME	MI
_____ SPOUSE _____ PARENT	STREET ADDRESS	CITY		STATE	ZIP CODE 4 DIGIT	
_____ GUARDIAN	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** ______