***WESTERN WASHINGTON MEDICAL GROUP*** ***REGISTRATION FORM***
***DEPARTMENT OF PSYCHOLOGY***

**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** _____ **GUARDIAN** | **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.

INITIALS VOICEMAIL #

***PATIENT SIGNATURE*** _____ ***DATE***

*For office use only*
**Dr.**_____ **Ins. code**_____ **Acct #** _____ **Initials** _____