WESTERN WASHINGTON MEDICAL GROUP
DEPARTMENT OF UROLOGY

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** ______