Western Washington Medical Group

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** _____ **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** _____