Western Washington Medical Group

REGISTRATION FORM

ACCOUNT#_____ **NEW** _____ **UPDATE** _____

PATIENT LAST NAME	**FIRST NAME (legal)**	**MI**	**PREFERRED OR NICKNAME**	**DATE OF BIRTH**

RACE	**ETHNICITY**	**PREFERRED LANGUAGE**	**SOCIAL SECURITY #**

SEX M ___ F ___ Other: _____ (Please List)	**GENDER IDENTITY:** __Genderqueer identifies as neither Male or Female __Identifies as Male __Female-to-male __Additional gender category or other, please specify _____ __Identifies as Female __Male-to-female __Choose not to disclose	**SEXUAL ORIENTATION** __ Choose not to disclose __ Heterosexual (straight) __ Bisexual __ Homosexual (gay/lesbian) __ Other _____

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** ( )	**PREFERRED EMAIL ADDRESS**

REFERRING DOCTOR	**HOW DID YOU HEAR OF US?** Internet ___ Google Maps ___ Friend/Family ___ Drove by location ___ Insurance Company ___ Mailer/ Marketing ___	**MARITAL STATUS** MARRIED _____ DIVORCED _____ OTHER _____ SINGLE _____ WIDOWED _____ SEPARATED _____
PRIMARY CARE DOCTOR		

PHARMACY NAME, PHONE NUMBER AND LOCATION

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 ___ OTHER ___	**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 ___ OTHER ___	**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.) _____ **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 __ Other __

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**