



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 by voicemail, text, email or portal, which may contain details of my medical condition. By voluntarily providing your mobile phone number to WWMG, you agree to receive recurring non-marketing SMS messages regarding appointment reminders, cancellation or rescheduling, patient onboarding, care-related notifications, and billing updates. Message frequency varies. Message and data rates may apply. Providing a mobile number and consenting to SMS messages are not required to receive medical treatment or services from WWMG. Reply HELP for help or STOP to opt out. View the WWMG Privacy Policy and SMS Terms and Conditions.									
INITIALS				VOICEMAIL #					
PATIENT SIGNATURE Type name for signature				DATE					
For office use only									
Dr. _____		Ins. code		Acct #		Initials			