LAKE WASHINGTON PRIMARY CARE, PLLC

PATIENT REGISTRATION

FOR OFFICE USE ONLY	
Acct. #	**Today's Date**
Entered By	**Checked By**

Patient Name (Last)	First	M.I.
Address		

City	State	Zip Code	Social Security # (OK to leave blank)	Birthdate	Age

Patient Home Phone #	Sex	Race 1 – Asian 2 – African-American 3 – White 4 – Hispanic 5- Native American 9 – Other

Marital Status Single-1 Married-2 Partnered-3 Divorced-4 Widowed-5	Spouse/Partner's Name	Spouse/Partner's phone number

Patient Cell Phone #	Patient Work Phone #	Referred by Whom to this Practice

RESPONSIBLE PARTY (Complete only if different from above information)

Responsible Party Name	Relationship to Patient

Address	City	State	Zip Code

Home Phone #	Work Phone #

EMPLOYMENT INFORMATION

Employer Name	Phone #

Address	City	State	Zip Code

EMERGENCY CONTACT (Not at same address)

Name	Relationship to Patient	Home/Cell Phone #	Work Phone #

PRIMARY INSURANCE

Primary Insurance Co.	Subscriber Name	

Relationship to Patient	Subscriber Birthdate	Policy Effective Date

Policy ID #	Group #

SECONDARY INSURANCE

Secondary Insurance Co.	Subscriber Name	

Relationship to Patient	Subscriber Birthdate	Policy Effective Date

Policy ID #	Group #

(Please Bring All Insurance Cards to your Appointment)

I authorize **Lake Washington Primary Care, PLLC** to provide medical treatment to me. I authorize my insurance company to directly pay **Lake Washington Primary Care, PLLC** for any medical treatment provided by Lake Washington Primary Care, PLLC payable under the terms of my insurance. I understand that I am financially responsible for charges incurred by me. In the event my account is turned over to an attorney for collection, I will be responsible for attorney fees and court costs. I further authorize **Lake Washington Primary Care, PLLC** to release medical information to any third party payer or government agency necessary to process my insurance claims, or to any other healthcare provider in order to provide treatment to me. A photocopy of this authorization shall be considered as valid as the original. This assignment shall remain in effect until revoked by me in writing.

_____ _____

Signature of Patient/Responsible Party Date