The Seattle Arthritis Clinic

10330 Meridian Ave N, Ste. 250 • Seattle, WA 98133 • Ph: (206) 368-6123 • Fax: (206) 368-6178

PATIENT REGISTRATION FORM

PATIENT NAME: **DATE:**

_____

Last *First* *MI* ☐ Male ☐ Female

Name you prefer to be called:

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Separated ☐ Divorced

Birth date: **Age:** **Social Security #:**

Address: **Apt#** **City:** **Zip:**

Home Phone: ( ) **Cell Phone: ( )**

Employer: **Work Phone: ( )**

Primary Physician: **Phone: ( )**

Referring Physician: **Phone: ( )**

Responsible Billing Party / Relation to Patient: ☐ Self ☐ Partner/Spouse ☐ Child ☐ Parent
(Please give address and phone if different from above)

Address: **Phone: ( )**

Emergency Contact: _____ **Relation:** _____

Day Phone: ( ) **Evening Phone: ( )**

Primary Insurance Carrier: _____ **Member ID#:** _____

Subscriber Name / Date of Birth: _____ **Group #:** _____

Secondary Insurance Carrier: _____ **Member ID#:** _____

Subscriber Name / Date of Birth: _____ **Group #:** _____

I have no insurance. I agree to pay today for the services provided by The Seattle Arthritis Clinic, P.S.

Signature: **Date:**

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the physician. I am financially responsible for the balance due. I understand that any and all non-covered services are my sole financial responsibility. I also authorize the doctor or insurance company to release information required for this claim. I also understand that if my insurance requires a referral, it is my responsibility to provide one to The Seattle Arthritis Clinic, P.S., at the time of service.

I, the patient/patient's legal representative, hereby grant permission to The Seattle Arthritis Clinic, P.S. to perform such examinations and medical or therapeutic procedures as may be deemed professionally necessary for my/the patient's diagnosis and treatment.

I acknowledge receipt of Northwest Hospital & Medical Center's *Notice of Privacy Practices.*

Signature: **Date:**