Patient Information* – *Please complete ENTIRE form

Today's Date _____

Date of Birth _____ Sex (circle one): Male Female ❒Single ❒Married ❒Widowed ❒Divorced

Name _____ Social Security # _____

REQUIRED FOR INSURANCE BILLING

Race (circle one)
American Indian/Alaska Native
Asian
Black/African American
Native Hawaiian/Other Pacific Islander
White
Undetermined

Ethnicity (circle one)
Hispanic/Latino
Non Hispanic/Latino
Undetermined

Patient E-mail address: _____

Address _____ **City** _____ **State** _____ **Zip** _____

Phone _____ _____ _____ Preferred method of contact: ❒Home ❒Work ❒Cell
Home *Work* *Cell*

Doctor who referred patient _____ **Doctor's phone #** _____

Patient employed by _____ **Patient occupation** _____

Emergency contact: Name _____ **Phone** _____ **Relationship** _____

Name _____ **Phone** _____ **Relationship** _____

Patient Insurance

CO-PAY $_____ ***Co-pay is due at time of service. There is an additional $10 charge if not collected.***

Primary Insurance _____ ID # _____ Group _____

Secondary Insurance_____ ID # _____ Group _____

Insured person's name _____ Relationship to patient _____

Insured person's date of birth _____ Insured person's SSN _____

➢ ***If the patient is a MINOR or has a POA, please complete the next two lines of information***

Parent/Guardian/POA Name _____ Relationship to patient _____

Parent/Guardian/POA date of birth _____ Parent/Guardian/POA SSN _____

➢ ***If your claim is to be billed to a worker's comp (L&I) or motor vehicle accident, please complete the following:***

Claim #: _____ Case manager Name/Phone #: _____

Please indicate which company we are billing this claim to:
- ❒ Labor and Industries
- ❒ Sedgwick
- ❒ Other self-insured _____
- ❒ Car accident insurer _____

Claim Mailing Address:
_____
_____

Date of injury: _____ Employer/Place of Injury: _____

Authorization Disclose Medical Information

I authorize the following people full access to my medical information including the ability to pickup written prescriptions for me, discussing my condition or treatment, or have access to my medical and billing records.

_____	_____
Name (please print)	Relationship (Parent, relative, legal guardian, personal rep)
_____	_____
Name (please print)	Relationship (Parent, relative, legal guardian, personal rep)
_____	_____
Name (please print)	Relationship (Parent, relative, legal guardian, personal rep)

_____ _____

Patient or legally authorized individual signature Date Time

_____

Printed Name

This form will be retained in your medical record. To get copies of your records contact 253-333-1637. Please allow 48 hours for any records request.