

Patient: _____
 Last Name First Name M.I. Age Date of Birth

Soc. Sec. # _____ **Sex: M / F** **Spouse Name:** _____

Mailing Address: _____
 City State Zip Code

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____ **Ext:** _____

Employer: _____ **Address:** _____

Emergency Contact (*not living at same address*)

Name: _____
Address: _____
Phone # _____
Relationship: _____

Referring Physician: _____
Phone # _____
Address: _____

Name of responsible party: _____
Relationship: _____
Address: _____
Phone # _____

Family Physician: _____
Phone # _____
Address: _____

INSURANCE INFORMATION

Primary: _____ **Copay:** _____
ID# _____ **Group#** _____
Subscriber's Name & D.O.B _____
Relationship to subscriber: _____

Secondary: _____ **Copay:** _____
ID# _____ **Group#** _____
Subscriber's Name & D.O.B: _____
Relationship to subscriber: _____

Is the purpose of your visit related to a motor vehicle accident? Yes _____ No _____ Date of accident: _____ State: _____

Is the purpose of your visit due to a work related injury? Yes _____ No _____ Date of injury: _____ State: _____

WA State Dept of L&I claim# _____ Case Manager & phone # _____

Self Insured - name & address of company _____
 Claim # _____ Case Manager & phone # _____

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize my insurance benefits be paid directly to the physician. I am financially responsible for any balance due. I also authorize the doctor or insurance company to release any information required for this claim.

Patient Signature: _____ **Date:** _____