

**PATIENT REGISTRATION**

*Please fill out completely*

Patient First Name: MI: Last Name:

Street Address: City: State: Zip:

Gender: M F Non-binary Transmale Transfemale Prefer Not to Answer Preferred Pronouns:

Home Phone: Cell Phone: Work Phone: SSN:

Date of Birth: Age: Occupation: 

Email: Primary Care Provider:

Referred by: Doctor Friend/Family Google Yelp Our Website Other

Employment: Employed F/T Student P/T Student Unemployed Retired Other

Marital Status: Single Married Partnered Divorced Other

Emergency Contact: Phone: Relationship: 

**PRIMARY INSURANCE**

Insurance Company: Phone: 

Claims Address: City: State: Zip:

Subscribers Name: Date of Birth:

Relationship to you: Self Spouse Dependent Other

ID # **as shown on card:**  Group #:

**SECONDARY INSURNACE OR AUTO/L&I**

Is this injury related? Y N Work related? Y N Auto Accident? Y N State: 

Insurance Company: Phone: 

Claims Address: City: State: Zip:

Subscribers Name: Date of Birth:

Relationship to you: Self Spouse Dependent Other

ID # **as shown on card:**  Group #:

*I understand that I am financially responsible for all charges and agree to pay for services. I authorize the health care provider to release to my insurance company(ies) any and all information necessary to process my claim.*