

glow

NATURAL HEALTH CENTER, PLLC

2719 E. Madison St. Suite 203

Seattle, WA 98122

Phone: 206 568 7545 Fax: 206 568 8298

PATIENT REGISTRATION

Please fill out completely

Date: _____

Patient Name: _____ MI: _____ Last: _____

Street Address: _____

City: _____ State: _____ Zip: _____

SSN: _____ Gender: ()M ()F Home ph: () _____

Occupation: _____ Work ph: () _____

Date of Birth: / / Age: _____ Alt ph: () _____

E-mail: _____ Referred by: _____ Primary care provider _____

Employment: Employed F/T Student P/T Student Retired Other
 Marital Status: Single Married Divorced Widowed Dependant Partnered Other

Parent / Guardian / Spouse / Partner: _____ Phone: () _____

Referred by: _____

In case of emergency contact: _____ Relationship: _____

Phone: () _____

PRIMARY INSURANCE

Insurance Company Name: _____ Phone: () _____

Claims Address: _____

City, State, Zip: _____

Subscriber's Name: _____ Date of Birth: / /

Relationship to you: Self Spouse Dependant Other

I.D. # as shown on card: _____ Group #: _____

Employer of Insured: _____

SECONDARY INSURANCE OR AUTO / L&I

Is this visit injury related? Y N Work related? Y N Auto accident? Y N State: _____

Insurance Company Name: _____ Phone: () _____

Claims Address: _____

City, State, Zip: _____

Subscriber's Name: _____ Date of Birth: / /

Relationship to you: Self Spouse Dependant Other

I.D./Claim # as shown on card: _____ Policy#: _____

Employer if applicable: _____ Effective / Injury Date: / /

I understand that I am financially responsible for all charges and agree to pay for services. I authorize the doctor to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize that payments be made directly to the physician.

Signature _____

Date _____