glow
NATURAL HEALTH CENTER, PLLC
2719 E. Madison St. Suite 203
Seattle, WA 98112
Phone: 206 568 7545 Fax: 206 568 8298

PATIENT REGISTRATION

Please fill out completely

Patient First Name: MI: Last:

Street Address:

City: State: Zip:

SSN: Gender: M F Home ph:

Occupation: Work ph:

Date of Birth: Age: Cell ph:

Email:

Primary care provider:

Referred by: ☐ Doctor _____ ☐ Friend/family _____ ☐ Google ☐Yelp ☐ Our Website ☐ Other _____

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

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Dependent ☐Other

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 ☐Dependent ☐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 ☐Dependent ☐Other

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

Employer if applicable: Injury Date:

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. I further authorize that payments be made directly to the health care provider.

Signature _____ **Date** _____

*Office use only: Entered/ Faxed on:*_____