18927 33rd Ave W Suite B, Lynnwood, WA 98036
Ph: 425.776.1177 | Fax: 425.776.5533

Patient Insurance Registration Form

NAME ______________________ **DATE OF BIRTH** ______________________

ADDRESS ______________________ **CITY** __________ **ZIP** __________

PHONE __________ **WORK** __________ **CELL** __________

EMAIL ______________________ **EMPLOYER/TITLE** ______________________

EMERGENCY CONTACT ______________________ **PHONE** ______________________

CIRCLE ONE : SINGLE MARRIED DIVORCED OTHER __________
EMPLOYED? YES/NO FULL TIME/PART TIME STUDENT? YES/NO
HOW WERE YOU REFERRED TO OUR OFFICE? ______________________

WILL BE BILLING YOUR INSURANCE? __________ (If yes, please fill out information below)

PRIMARY INSURANCE ______________________

ADDRESS ______________________ CITY ______________________

STATE __________ ZIP __________ SS# __________

SUBSCRIBER NAME ______________________ EMPLOYER ______________________

PATIENT RELATIONSHIP TO SUBSCRIBER: self spouse child step child other

INSURANCE I.D. # (include letter prefix) ______________________

GROUP # ______________________

SECONDARY INSURANCE ______________________

ADDRESS __________ CITY __________ STATE __________ ZIP __________

SUBSCRIBER NAME ______________________ DOB ______________________

SS# __________ SUBSCRIBER EMPLOYER ______________________

PATIENT RELATIONSHIP TO SUBSCRIBER: self spouse child step child other

INSURANCE ID # (please include letter prefix): ______________________

GROUP # ______________________