

Please print, fill in, and bring with you for your office visit



Today's Date:	
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REGISTRATION FORM

Patient

Name (Last, First, M.I.):		Maiden name:	
Social security number	Date of Birth:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	
Street Address	City	St	Zip
Preferred Contact Number: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell			
Home Phone	Work Phone	Cell Phone	
Marital status:	Emergency Contact and Phone:		
<input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			

Employer

Employer Name
Employer Address

Primary Insurance

Insurance Company Name:	Copay:
Subscriber's ID:	Group Number:
Subscriber's Name:	Subscriber's employer:
Subscriber's DOB:	Subscriber's gender: <input type="checkbox"/> M <input type="checkbox"/> F
Relationship to Subscriber:	

Secondary Insurance

Insurance Company Name:	Copay:
Subscriber's ID:	Group Number:
Subscriber's Name:	Subscriber's employer:
Subscriber's DOB:	Subscriber's sex: <input type="checkbox"/> M <input type="checkbox"/> F
Relationship to Subscriber:	

Responsible Party (who is in responsible for any balances on this account?)

<input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> L & I <input type="checkbox"/> Worker's Comp. <input type="checkbox"/> Employer Contract			
Social Security Number	Name (Last, First, M.I.):		
Street Address	City	St	Zip
Home Phone	Work Phone	Cell Phone	
Worker's Compensation/ L&I Claim Number:	Date of Injury:		
Employer Name:			

Referred By (how were you referred to the Institute of Complementary Medicine?)

<input type="checkbox"/> Insurance directory <input type="checkbox"/> Website <input type="checkbox"/> Yellow pages <input type="checkbox"/> Friend <input type="checkbox"/> Relative <input type="checkbox"/> Physician			
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Whom may we thank? Name

I, the patient or guarantor, certify that the information on this form is true to the best of my knowledge. I accept responsibility for the medical charges incurred by the patient and agree to pay all bills at the time of service unless other arrangements are made. I authorize physician and clinic to release any information to process insurance claims. I authorize my insurance claim to be paid directly to the clinic.

Signature:	Date: